INTRODUCTION

Dear Employee:

Blue Cross and Blue Shield of Louisiana (Blue Cross) is pleased to provide administrative services for your Employer's Group Health Plan as outlined in this national Preferred Provider Organization (PPO) health Benefit program to the Employees of Society of the Roman Catholic Church of the Diocese of Lafayette. Blue Cross provides you and your family members with cost effective health care administration on a nationwide basis.

Your new health care coverage is effective January 1, 2014. Please refer to the Benefits outlined in this Plan of Benefits as your health care coverage needs arise.

The Blue Cross and Blue Shield network offers the best geographic access to Physicians and Hospitals of any PPO in the nation. This national coverage is available through the BlueCard® Program in which all Blue Cross and Blue Shield Plans participate. To learn more about the BlueCard Program or to determine if your Physician participates in the BlueCard Program, visit the Blue Cross and Blue Shield Association's (BCBSA) website at **www.BCBS.com** or our website at **www.MyHealthToolkitLA.com**.

We welcome you to our family of health care coverage through Blue Cross and look forward to serving you.

Employer Name:	Society of the Roman Catholic Church of the Diocese of Lafayette
Employer Number:	71-60471-00 and appropriate subgroups 71-60472-00 and appropriate subgroups
Effective Date:	January 1, 2014

This Employer believes this Plan of Benefits is a "grandfathered health Plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health Plan means that this Plan of Benefits may not include certain consumer protections of PPACA that apply to other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health Plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health Plan and what might cause a plan to change from grandfathered health Plan status can be directed to the Plan Administrator or call the number on the back of your Identification (ID) Card.

TABLE OF CONTENTS

VISIT OUR WEBSITE AND MOBILE SITE

Our member website, **www.MyHealthToolkitLA.com** is a source for instant, personalized Benefits and health information. As a member, you can take full advantage of this interactive website to complete a variety of self-service transactions online — twenty-four (24) hours a day, seven (7) days a week — from wherever you have internet access. ***Need to order replacement member ID card? Need to check the status of a claim or download claim forms? Need to print an explanation of benefits (EOB)?***

You also can use such self-help tools as:

View **real-time status** of your eligibility, Benefit Year Deductible, Out-of-Pocket Maximum and any health care account balances.

The **Doctor and Hospital Finder** is where you get the most recent information on our network of medical Providers and Hospitals. Search by name, address, gender, specialty and Hospital affiliation. You can also get information about medical schools attended, board certification status, languages spoken, handicap access, maps and driving directions.

Within the Doctor and Hospital Finder, you can see your estimated out-of-pocket costs for over one hundred (100) treatment cost categories. Treatment cost categories include inpatient and outpatient procedures like Magnetic Resonance Imaging (MRIs) and Surgical Services. Costs are displayed by place of service and you can compare up to three facilities on cost and quality. Your out-of-pocket costs displayed on the website are based on your Plan design and your real-time Benefit Year Deductible and Out-of-Pocket Maximum status. Your estimated costs will include any Copayment, Benefit Year Deductible and Coinsurance you would owe.

Our **Personal Health Record (PHR)** is more than a place to store your health information. It may also send you health alerts and reminders to help you address your health needs. Anytime a medical or lab claim is processed the information is fed to your PHR. You can print medication lists, add doctor’s appointments and read up to date health and wellness articles.

The **Personal Health Assessment (PHA)** is a confidential online survey that can help you identify your personal risk factors while guiding you toward healthier lifestyle choices. Best of all, there's no cost to you! Once you've completed the survey, you'll get your Personal Health Assessment wellness score right away. You can use the wellness score as a baseline for evaluating and improving your health. The assessment also gives tips for lowering risk factors. You can print your report or refer back to it online as long as you keep your coverage.

On the go? The My Health Toolkit mobile website offers Covered Members features designed for smaller smartphone screens. Unlike some mobile tools, as a BlueCross member, you do not need to download an app. When you want to access the mobile site, simply navigate to **www.MyHealthToolkitLA.com** on your smartphone.

Preferred Provider Plan
Employer Health Coverage

This booklet explains how your coverage works and how Benefits are paid.

Important information about your health coverage:

You must get Preauthorization, when required, before getting medical care. The amount you have to pay for services and supplies will increase when you do not get Preauthorization.

Under your Employer's health Plan, the Benefits you receive will depend on whether the Provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum Benefits that can be paid if you use Participating Providers and you get Preauthorization, when required, before getting medical care. The amount you have to pay will increase when you do not use Participating Providers and if you do not get Preauthorization.

Members of the BCBSA attempt to contract with Providers that practice at Participating Hospitals but may contract as Traditional Providers (hereafter referred to as Non-Participating Providers) and therefore, services performed by these Physicians will be paid at the Non-Preferred Provider level of Benefits, however, you should not be balance billed. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider you have no protection from balance billing from the Provider. Non-Participating Providers will be paid at the Non-Preferred Provider level of Benefits with no protection from balance billing (with the exception of Traditional Providers) from the Provider.

Please refer to the section entitled "Definitions and Coverage Requirements" for a detailed description of Participating and Non-Participating Providers, and how you get approval for Benefits to be paid for Medically Necessary services or supplies.

Blue Cross (hereafter referred to as Corporation) is the Claims Administrator for this Preferred Provider Plan. Blue Cross has retained Planned Administrators, Inc. as a primary provider of claims processing, customer service, and other services and BlueCross BlueShield of South Carolina as provider of medical management services.

IMPORTANT INFORMATION

How to get help with claims, Benefit questions or complaints:

- 1- 855-215-0280

TTY users please call:

- 1-800-735-8583

How to get help with Preauthorization:

- 1-888-376-6544

(Please do not call this number for claims inquiries)

Preauthorization is required as set forth on the Schedule of Benefits or in the section entitled "Health Care Services".

How to get help with Preauthorization for Mental Health Services:

Behavioral Health:

- 1-800-868-1032

How to get information on Prescription Drug coverage:

Drug coverage is handled by Caremark. **For inquiries regarding the Prescription Drug Benefit please call:**

- 1-888-963-7290

For inquiries regarding the Specialty Drug Benefit, please call Accredo:

- 1-877-512-5981

You can also access Caremark or Accredo from our website, **www.MyHealthToolkitLA.com**.

How to get help for Disease Management

Your Employer will provide you with access to the ***Disease Management Program***. Disease Management gives Covered Members with any of the following diseases the opportunity to learn more about their conditions and how they can better care for themselves:

- Asthma
- Cardiovascular diseases: hypertension (high blood pressure), hyperlipidemia (high cholesterol), coronary artery disease & heart failure
- Diabetes
- Chronic lung problems (COPD)

Covered Members identified as having any of the conditions above will automatically be enrolled in Disease Management. They will have access to Web tools, educational resources and health coaches to help them successfully manage their chronic disease. For Covered Members that do not want to participate, call: 1-800-868-2500, dial one and then extension 49043 to disenroll.

How to get help on Personal Health Assessment

Your Employer provides you with access to ***Personal Health Assessment***, an online health risk assessment that allows Covered Members to evaluate their wellness potential and receive instant feedback with suggestions for healthy lifestyle changes. To access ***Personal Health Assessment*** visit **www.MyHealthToolkitLA.com**.

BLUECARD PROGRAM

Out-of-Area Services

BCBSLA has a variety of relationships with other Blue Licensees referred to generally as "Inter-Plan Programs." Whenever Covered Members obtain healthcare services outside of Blue Cross and Blue Shield of Louisiana's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program.

Typically, when accessing care outside Blue Cross and Blue Shield of Louisiana's service area, Covered Members will obtain care from healthcare Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Covered Members may obtain care from non-participating healthcare Providers. BCBSLA's payment practices in both instances are described below.

1. BlueCard® Program

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

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

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

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

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

Laws in a small number of states may require the Host Blue to add a surcharge to a calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSLA would then calculate your liability for any covered healthcare services according to applicable law.

2. Medicare Supplemental/Medigap/Medicare Complementary

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

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

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

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

a. Covered Member Liability Calculation

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

b. Exceptions

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

c. Medigap/Medicare Supplemental/Medicare Complementary Plans

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

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for health care services they rendered to you. However, in the event a Provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an explanation of benefits (EOB) through our website or by contacting customer service. An EOB will also be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the website. You may also call us at the telephone numbers listed on your Identification (ID) Card and we will send you a form. After filling out the claim form, send it to the address below:

BlueCross BlueShield
Post Office Box 100121
Columbia, South Carolina 29202

CLAIMS FILING AND APPEALS PROCEDURES

Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Covered Member's behalf or provide an electronic means for the Covered Member to file a claim while the Covered Member is in the Participating Provider's office. However, the Covered Member is responsible for ensuring that the claim is filed.

Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address listed in the booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Covered Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Covered Member. If the claim form is not furnished within fifteen (15) days after the Corporation receives the notice, the Covered Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Covered Member must submit written proof covering the character and extent of the services within the policy time fixed for filing proof of loss.

For Benefits not provided by a Participating Provider, the Covered Member is responsible for filing claims with the Corporation. When filing the claims, the Covered Member will need the following:

- A claim form for each Covered Member. Covered Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, **www.MyHealthToolkitLA.com**.

- Itemized bills from the Provider (s). These bills should contain all the following:

    - Provider's name and address;
    - Covered Member's name and date of birth;
    - Covered Member's Identification Card number;
    - Description and cost of each service;
    - Date that each service took place; and
    - Description of the illness or injury and diagnosis.

- Covered Members must complete each claim form and attach the itemized bill(s) to it. If a Covered Member has other insurance that already paid on the claim(s), the Covered Member should also attach a copy of the other Plan's EOB notice.

- Covered Members should make copies of all claim forms and itemized bills for the Covered Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

The Corporation must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Covered Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Covered Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation. The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Covered Member's claim will be deemed to be acting as the agent of the Covered Member. If the Covered Member desires to appoint an Authorized Representative in connection with such Covered Member's claims, the Covered Member should contact the Corporation for an Authorized Representative form.

There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Employer's Group Health Plan will make a determination for each type of claim within the following time periods:

Pre-Service Claim

A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

If a Pre-Service Claim is improperly filed, or otherwise does not follow applicable procedures, the Covered Member will be sent notification within five (5) days of receipt of the claim.

An extension of fifteen (15) days is permitted if the Corporation (on behalf of the Employer's Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Covered Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Covered Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference the section entitled "Appeal Procedures for an Adverse Benefit Determination" below for details regarding the appeals process.

Urgent Care Claim

A determination will be sent to the Covered Member in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

If the Covered Member's Urgent Care Claim is determined to be incomplete, the Covered Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Covered Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

If the Covered Member requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Covered Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

Post-Service Claim

A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

An extension of fifteen (15) days may be necessary if the Corporation (on behalf of the Employer's Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Covered Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Covered Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference the section entitled "Appeal Procedures for an Adverse Benefit Determination" below for details regarding the appeals process.

Concurrent Care Claim

The Covered Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Covered Member time to appeal the decision before the Benefits are reduced or terminated.

Notice of Determination

If the Covered Member's claim is filed properly, and the claim is in part or wholly denied, the Covered Member will receive notice of an Adverse Benefit Determination that will:

- State the specific reason(s) for the Adverse Benefit Determination;
- Reference the specific Plan of Benefits provisions on which the determination is based;
- Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
- Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Covered Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;
- Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,
- If the reason for denial is based on a lack of Medical Necessity or an Experimental and Investigational Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

The Covered Member will also receive a notice if the claim is approved.

APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

A Covered Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

- An appeal must be in writing; and,

- An appeal must be sent (via U.S. mail) to the address below:

  BlueCross BlueShield
  Post Office Box 100121
  Columbia, South Carolina 29202

- The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

- An appeal must include the Covered Member's name, address, identification number and any other information, documentation or materials that support the Covered Member's appeal.

The Covered Member may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

If the appealed claim involves an exercise of medical judgment, the Employer will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

The final decision on the appeal will be made within the time periods specified below:

Pre-Service Claim

The Corporation (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Covered Member disagrees with the Corporation's decision, the Covered Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Employer will decide the second appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the second appeal.

Urgent Care Claim

The Covered Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made verbally, and the Employer will communicate with the Covered Member by telephone or facsimile. The Employer will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

Post-Service Claim

The Corporation (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the appeal. If the Covered Member disagrees with the Corporation's decision, the Covered Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Employer will decide the second appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the second appeal.

Concurrent Care Claim

The Employer will decide the appeal of Concurrent Care Claims within the time frames set forth in the three previous paragraphs depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

Notice of Appeals Determination

If a Covered Member's appeal is denied in whole or in part, the Covered Member will receive notice of an Adverse Benefit Determination that will:

- State specific reason(s) for the Adverse Benefit Determination;
- Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;

- State that the Covered Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
- Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);
- If the reason for denial is based on a lack of Medical Necessity or an Experimental and Investigational Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and,
- Include a statement regarding the Covered Member's right to bring an action under section 502(a) of ERISA.

The Covered Member will also receive a notice if the claim on appeal is approved.

The Employer may retain the Corporation to assist the Employer in making the determination on appeal. Regardless of its assistance, the Corporation is only acting in an advisory capacity and is not acting in a fiduciary capacity. The Employer at all times retains the right to make the final determination.

ELIGIBILITY REQUIREMENTS

Active Employees\Grandfathered Employees
Full-time, active Employees and their Dependents are eligible for coverage on the first monthly effective date following the date of hire, including grandfathered Employees. An active Employee is an Employee who is Actively at Work as defined in the section entitled "DEFINITIONS AND COVERAGE REQUIREMENTS". If application is not made within the first thirty-one (31) days of eligibility, the application cannot be made until the next open enrollment period, family status change or Special Enrollment period.

Retirees
Retired lay Employees and spouses are eligible for coverage upon retirement when the following conditions are met:

- Employment is terminated after ten (10) or more consecutive years of active employment with Society of the Roman Catholic Church of the Diocese of Lafayette, and
- Continuously maintained Society of the Roman Catholic Church of the Diocese of Lafayette coverage for a period of at least ten (10) years immediately prior to the effective date of retirement.
- The retiree is eligible for and participates in Parts A and B of Medicare. Medicare coverage will be primary.

Notwithstanding the preceding paragraph, a qualified retired lay Employee who terminates employment on or after January 1, 2005 shall be able to enroll for Retired Employee Coverage, and must be able to do so within thirty-one (31) days of effective date of Retirement.

A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits.

For a Dependent to be eligible for coverage under this Plan of Benefits, the required Premium and administrative charge must be paid, prior to the termination of the enrollment period.

If an Employee is not enrolled such Dependents are not eligible to enroll for coverage under this Plan of Benefits.

Membership Application
The Corporation will only accept a Membership Application submitted by the Employer on behalf of each Employee. The Corporation will not accept a Membership Application directly from an Employee or Dependent.

Member Contributions
The Covered Member is solely responsible for making all payments for any Dependent Premiums.

Disclosure of Medical Information
By accepting Benefits or payment of Covered Expenses, the Covered Member agrees that the Employer's Group Health Plan (including BlueCross BlueShield on behalf of the Employer's Group Health Plan) may obtain claims information, medical records, and other information necessary for the Employer's Group Health Plan to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits.

Election of Coverage
Any Employee may enroll for coverage under the Employer's Group Health Plan for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Employer. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents may also enroll if eligible under the terms of any Special Enrollment procedure.

Commencement of Coverage
Coverage under the Employer's Group Health Plan will commence as follows:

- Employees and Dependents Eligible on the Employer's Effective Date

  For Employees (and such Employee's Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer effective date will generally commence on the Plan of Benefits Effective Date.

  If the Corporation receives an Employee's Membership Application dated after the Employer effective date, coverage will commence on the date chosen by the Employer. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

- Employees and Dependents Eligible After the Plan of Benefits Effective Date

  Employees and Dependents who become eligible for coverage after the Plan of Benefits Effective Date and have elected coverage will have coverage after they have completed the Probationary Period. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

- Dependents Resulting from Marriage

  Dependent(s) resulting from the marriage of an Employee will have coverage upon enrollment provided they have enrolled for coverage and the coverage must be paid for under this Plan of Benefits within thirty-one (31) days after marriage. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

- Newborn Children

  A newborn Child will have coverage upon enrollment provided he or she has been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within thirty-one (31) days after the Child's birth for the Child to have coverage from the date of birth. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

- Adopted Children

  For an adopted Child of an Employee, coverage shall commence as follows:

  - Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth;
  - Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth, and if the Employee has obtained temporary custody of the Child;
  - For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits;
  - If an adopted Child is not enrolled within the time frame set forth in bullets above, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium and administrative charge.
  - Notwithstanding the preceding paragraph, coverage will not be effective more than sixty (60) days prior to the date that the Corporation receives such Employee's Membership Application.

- Special Enrollment

  In addition to enrollment under the "ELIGIBILITY REQUIREMENTS" section, the Corporation shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

  - The Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent; and,
  - The Employee stated in writing at the time of enrollment, that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and,
  - The Employee or Dependent's coverage described above:
    - Was under a ontinuation coverage provision and the coverage under the provision was exhausted; or,

- Was not under a continuation coverage provision described in the previous paragraph above, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment), or reduction in the number of hours of employment, or if the Employer's contributions toward the coverage were terminated; or,
- Was one of multiple Plans offered by an employer and the Employee elected a different plan during an open enrollment period or when an employer terminated all similarly situated individuals; or,
- Was under an HMO that no longer serves the area in which the Employee lives, works or resides; or,
- Was under a Plan where the Covered Member incurs a claim that would meet or exceed a lifetime limit on all Benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all Benefits; or,
- Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described above, or termination of coverage or Employer contribution described above.

o Medicaid or State Children's Health Insurance Program (SCHIP) Coverage:
- The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or
- The Employee or Dependent becomes eligible for assistance under a Medicaid or SCHIP plan; and
- The Employee or Dependent requests such enrollment not more than sixty (60) days after either:
  i. Date of termination of Medicaid or SCHIP coverage; or
  ii. Determination that the Employee or Dependent is eligible for such assistance.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above see the Employer.

TERMINATION OF THIS PLAN OF BENEFITS

GENERALLY

TERMINATION OF AN EMPLOYEE'S COVERAGE AND ALL OF SUCH EMPLOYEE'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING DATES:

- The date the Employer's Group Health Plan is terminated pursuant to the remaining terms under this section.
- The date an Employee retires unless the Employer's Group Health Plan covers such individual as a retiree.
- The last day of the month in which an Employee ceases to be eligible for coverage as set forth in the section entitled "Eligibility Requirements".
- The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed twelve (12) weeks from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993. Upon termination, eligible Employees may extend Benefits for up to eighteen (18) months immediately following the last day of the month for which the Employee's Premium has been paid by the Employer. Covered Members should contact the Diocesan Office of Human Resources (337-261-5562) for more information.
- In addition to terminating when an Employee's coverage terminates, a Dependent spouse's coverage terminates on the date of entry of a court order ending the marriage between the Dependent spouse and the Employee regardless of whether such order is subject to appeal.
- In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Plan of Benefits.
- In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent.
- Death of the Employee.

TERMINATION FOR FAILURE TO PAY PREMIUMS

In the event of termination for failure to pay Premiums, Premiums received after termination will not automatically reinstate the Employee in participation under the Employer's Group Health Plan. If the Employee's participation in the Employer's Group Health Plan is not reinstated, the late Premium will be refunded to the Employee.

TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health Benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium. If Premiums are not paid by an Employee coverage ends as of the due date of that Premium contribution.

NOTICE OF TERMINATION TO COVERED MEMBERS

If the Employer's Group Health Plan is terminated for any reason, the Employer is solely responsible for notifying all Covered Members of such termination and that coverage will not continue beyond the termination date.

REINSTATEMENT

The Employer's Group Health Plan in its sole discretion (and upon such terms and conditions as any stop-loss carrier or the Employer may determine) may reinstate coverage under the Employer's Group Health Plan that has been terminated for any reason. If a Covered Member's coverage (and including coverage for the Covered Member's Dependents) for Covered Expenses under the Employer's Group Health Plan terminates while the Covered Member is on leave pursuant to the Family and Medical Leave Act because the Covered Member fails to pay such Covered Member's Premium, the Covered Member's coverage will be reinstated without new Probationary Periods if the Covered Member returns to work immediately after the leave period, re-enrolls, and within thirty-one (31) days following such return pays all such Employee's portion of the past due amount and then current Premium.

EMPLOYER IS AGENT OF COVERED MEMBERS

By accepting Benefits, a Covered Member agrees that the Employer is the Covered Member's agent for all purposes of any notice under the Employer's Group Health Plan. The Covered Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by law to be given to the Covered Members by the Corporation.

SCHEDULE OF BENEFITS
Diocese of Lafayette Lay Employees

This table is a Schedule of Benefits and is subject to all other terms and conditions of the Plan:

To maximize your Benefits, seek medical services from a Participating Provider who participates in the Preferred Provider Organization (PPO). Please call 1-800-810-2583 or access our website at www.MyHealthToolkitLA.com to find out if your Provider is a Participating Provider.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Covered Members subject to the terms of the Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Covered Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**		
Effective date	01/01/14	
Benefit Year	This Schedule of Benefits applies from 01/01 through 12/31	
Initial Benefit Year	01/01/14 – 12/31/14	
Anniversary date	01/01	
	PPO Providers	**Non-PPO Providers**
Benefit Year Deductible	$500 per Covered Member per Benefit Year; limited to 3 per family.	$500 per Covered Member per Benefit Year; limited to 3 per family.
Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Preferred Provider and Non-Preferred Provider Benefit Year Deductibles.		
Annual Out-of-Pocket Maximum	$1,500 per Covered Member at a Participating Provider. Benefit Year Deductibles and Copayments do not contribute to the Out-of-Pocket Maximum determination. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met.	There is no Annual Out-of-Pocket Maximum for Non-PPO Providers.
Pre-Existing Condition Waiting Period:	There is no Pre-Existing Condition Waiting Period under this Plan of Benefits. See the ELIGIBILITY REQUIREMENTS section of the Plan of Benefits for information on qualifying for Special Enrollment.	
Dependent Child, in addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	A Child under the age of 26.	
Covered Expenses incurred during the last three (3) months of a Benefit Year, which are applied toward satisfying that year's Benefit Year Deductible will be carried over and applied toward satisfying the next year's Benefit Year Deductible.		

INPATIENT HOSPITAL (other than Mental Health Services)* Semiprivate room and board, and Special Care Units		
Benefit	**PPO Providers**	**Non-PPO Providers**
Hospital charges for room and board related to Admissions	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Skilled Nursing Facilities, limited to 30 days per Covered Member per Benefit Year	80% of the PPO Allowance, subject to the Benefit Year Deductible (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible (Pre-Certification required)
Inpatient physical Rehabilitation services	80% of the PPO Allowance, subject to the Benefit Year Deductible (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible (Pre-Certification required)
*Preadmission certification is required for all Admissions; Emergency Admissions require notification within 24 hours of Admission or by close of business the next business day; for Pre-Certification call 1-888-376-6544. If Pre-Certification is not obtained, there will be a 50% penalty of the Allowable Charges for Admissions.		
Maternity Care	**PPO Providers**	**Non-PPO Providers**
Hospital charges	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Routine nursery charges	80% of the PPO Allowance	60% of the Allowable Charge
Physician charges, including newborn care	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
OUTPATIENT HOSPITAL (other than Mental Health Services)		
Benefit	**PPO Providers**	**Non-PPO Providers**
Emergency room	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Surgery	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Maternity	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Medical	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Diagnostic lab and x-ray	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible

PHYSICIAN SERVICES		
Benefit	**PPO Providers**	**Non-PPO Providers**
Diagnostic lab and x-ray	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Surgery, in-Hospital visits, Second Surgical Opinions and inpatient and outpatient consultations	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Physician office services, including surgery, Allergy Injections, Physical Therapy, occupational therapy, Mental Health Services, lab and x-ray, dialysis treatment, Second Surgical Opinion and obesity-related services	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
PREVENTIVE CARE SERVICES		
Benefit	**PPO Providers**	**Non-PPO Providers**
Routine Well Baby Care/Well Child Care	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Routine Physical, including well women exams	80% of the PPO Allowance, subject to the Benefit Year Deductible; limited to one physical exam per Benefit Year	60% of the Allowable Charge, subject to the Benefit Year Deductible; limited to one physical exam per Benefit Year
Routine mammography screening for age 35 and above	80% of the PPO Allowance, subject to the Benefit Year Deductible; limited to one annual exam for women	60% of the Allowable Charge, subject to the Benefit Year Deductible; limited to one annual exam for women
Prostate screening (interpretation & lab work only)	80% of the PPO Allowance, subject to the Benefit Year Deductible; limited to one screening per Benefit Year	60% of the Allowable Charge, subject to the Benefit Year Deductible; limited to one screening per Benefit Year
Pap Smear screening (interpretation & lab work only)	80% of the PPO Allowance, subject to the Benefit Year Deductible; limited to one screening per Benefit Year	60% of the Allowable Charge, subject to the Benefit Year Deductible; limited to one screening per Benefit Year
Routine immunizations	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Flu immunizations (including Flu Mist)	100% of the PPO Allowance	100% of the Allowable Charge
Routine colonoscopy	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Bone density screening	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible

OTHER COVERED SERVICES		
Benefit	**PPO Providers**	**Non-PPO Providers**
Durable Medical Equipment, prosthetics, Orthopedic Devices and Orthotics	80% of the PPO Allowance, subject to the Benefit Year Deductible Preauthorization is required for all Durable Medical Equipment with a purchase or total rental price of $500 or more.	60% of the Allowable Charge, subject to the Benefit Year Deductible Preauthorization is required for all Durable Medical Equipment with a purchase or total rental price of $500 or more.
Habilitation and Rehabilitation related to speech therapy, limited to 30 visits per Covered Member per Benefit Year	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Habilitation and Rehabilitation related to occupational and Physical Therapy	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Vision therapy for non-surgical treatment of eye muscles, limited to a maximum of 30 treatments per Covered Member per lifetime	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Private duty nursing (when associated with Home Health Care) limited to a Maximum Payment of $10,000 per Covered Member per lifetime	80% of the PPO Allowance, subject to the Benefit Year Deductible (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible (Pre-Certification required)
Clinical pathology	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Preadmission testing	100% of the PPO Allowance	60% of the Allowable Charge, subject to the Benefit Year Deductible
Ambulance Services (including air ambulance)	80% of the PPO Allowance, subject to the Benefit Year Deductible	80% of the Allowable Charge, subject to the PPO Benefit Year Deductible
Human organ and tissue transplant services	80% of the PPO Allowance, subject to the Benefit Year Deductible (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible (Pre-Certification required)
Travel & lodging for human organ and tissue transplant services for donors, recipients and their family members, limited to a combined Maximum Payment of $10,000 per Covered Member per transplant	80% of the PPO Allowance, subject to the Benefit Year Deductible	80% of the Allowable Charge, subject to the Benefit Year Deductible
Chiropractic Services, including spinal manipulation/subluxation, extra spinal manipulation, chiropractic modalities, chiropractic office visits and x-rays	50% of the PPO Allowance, subject to the Benefit Year Deductible	50% of the Allowable Charge, subject to the Benefit Year Deductible

Treatment for Morbid Obesity	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Treatment for obesity	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Treatment for Temporomandibular Joint Disorder (TMJ) limited to a Maximum Payment of $2,500 per Covered Member per lifetime*	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Impacted Tooth Removal	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Wigs, after chemotherapy treatment, limited to a combined maximum of one (1) per Covered Member per lifetime	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Treatment of sacroiliac joint pain	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Supplemental accident Benefits (the first $300 incurred per Benefit Year is payable at 100% and is not subject to the Benefit Year Deductible)	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Orthognathic Surgery limited to a Maximum Payment of $2,500 per Covered Member per lifetime*	Covered	Covered
***Treatment for Temporomandibular Joint Disorder (TMJ) and Orthognathic Surgery are limited to a combined Maximum Payment of $2,500 per Covered Member per lifetime.**		
HOME HEALTH AND HOSPICE CARE		
Benefit	**PPO Providers**	**Non-PPO Providers**
Home Health Care	80% of the PPO Allowance, subject to the Benefit Year Deductible; limited to a combined PPO and Non-PPO maximum of 30 visits per Covered Member per Benefit Year. (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible; limited to a combined PPO and Non-PPO maximum of 30 visits per Covered Member per Benefit Year. (Pre-Certification required)
Hospice Care, limited to 6 months per lifetime	80% of the PPO Allowance, subject to the Benefit Year Deductible (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible (Pre-Certification required)
MENTAL HEALTH SERVICES		
Benefit	**PPO Providers**	**Non-PPO Providers**
Inpatient Hospital services	80% of the PPO Allowance, subject to the Benefit Year Deductible (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible (Pre-Certification required)

Inpatient Physician Services	80% of the PPO Allowance, subject to the Benefit Year Deductible (Pre-Certification required)	60% of the Allowable Charge, subject to the Benefit Year Deductible (Pre-Certification required)
Outpatient Hospital services or clinic charges	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Outpatient Physician Services	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Emergency room facility services	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible
Emergency room Physician Services	80% of the PPO Allowance, subject to the Benefit Year Deductible	60% of the Allowable Charge, subject to the Benefit Year Deductible

PRESCRIPTION DRUGS			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Network Pharmacy**	**Non-Participating Network Pharmacy**
Generic Drugs	Non-covered	Prescription Drugs will be covered at 100% after a $10 Copayment, up to a 31 day supply Prescription maintenance drugs will be covered at 100% after a $30 Copayment, up to a 90 day supply	No Benefits are available for Prescription Drugs purchased from Non-Participating Pharmacies
Brand Name Drugs with no generic equivalent	Non-covered	Prescription Drugs will be covered at 100% after a $20 Copayment, up to a 31 day supply* Prescription maintenance drugs will be covered at 100% after a $60 Copayment, up to a 90 day supply*	No Benefits are available for Prescription Drugs purchased from Non-Participating Pharmacies
Brand Name Drugs with a generic equivalent	Non-covered	Prescription Drugs will be covered at 100% after a $30 Copayment, up to a 31 day supply* Prescription maintenance drugs will be covered at 100% after a $90 Copayment, up to a 90 day supply*	No Benefits are available for Prescription Drugs purchased from Non-Participating Pharmacies

PRESCRIPTION DRUGS (continued)			
If the Employer has elected to include the following as Benefits under the Plan of Benefits (as shown by a "Covered" notation below), Covered Expenses will be paid at the above listed Prescription Drug rates.			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Network Pharmacy**	**Non-Participating Network Pharmacy**
Contraceptive (Prescription Drugs)	Non-covered	Non-covered	Non-covered
Tobacco cessation Prescription Drugs	Non-covered	Non-covered	Non-covered
Obesity/weight control Prescription Drugs	Non-covered	Non-covered	Non-covered
Diabetic supplies**	Non-covered	Covered	Non-covered
Sexual dysfunction Prescription Drugs	Non-covered	Non-covered	Non-covered
Infertility Prescription Drugs	Non-covered	Non-covered	Non-covered
Cosmetic Prescription Drugs	Non-covered	Non-covered	Non-covered
***Including Specialty Drugs.** ****A separate Copayment applies for each supply purchase.**			

MEDICAL EXCLUSIONS

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN OF BENEFITS. THE ONLY EXCEPTIONS TO THIS ARE AS FOLLOWS: (1) WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED (UP TO THE CORRESPONDING DOLLAR AMOUNT AND/OR COVERAGE PERCENTAGE) IN THE SCHEDULE OF BENEFITS OR IN THE SECTION ENTITLED "DEFINITIONS AND COVERAGE REQUIREMENTS", OR (2) SERVICES RENDERED BY A HEALTH CARE PROVIDER AS PART OF A PHYSICIAN INCENTIVE PROGRAM (E.G. PATIENT-CENTERED MEDICAL HOME PROGRAM), AN ACCOUNTABLE CARE ORGANIZATION OR EPISODE-BASED ARRANGEMENT OR (3) AS THE LAW REQUIRES (I.E. INTENTIONAL OR UNREASONABLE INJURIES OR ILLNESSES THAT RESULT FROM MEDICAL CONDITIONS OR DOMESTIC VIOLENCE). SUBJECT TO THE ABOVE-LISTED EXCEPTIONS, THE EMPLOYER'S GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

1. Services and supplies that are not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting;
2. Admissions or portions thereof for Custodial Care or long-term acute care, including the following: rest care; long-term acute or chronic psychiatric care; care to assist a Covered Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication); care in a sanitarium; custodial or long-term care; or psychiatric or Substance Abuse residential treatment, including residential treatment centers; therapeutic schools; wilderness/boot camps; therapeutic boarding homes; half-way houses; and therapeutic group homes;
3. This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic and are not covered are: rhinoplasty (nose); mentoplasty (chin); rhytidoplasty (face lift); glabellar rhytidoplasty (forehead lift); surgical planing (dermabrasion); blepharoplasty (eyelid); mammoplasty (reduction, suspension or augmentation of the breast); superficial chemosurgery (chemical peel of the face); and, rhytidectomy (abdomen, legs, hips, buttocks, or elsewhere including lipectomy or adipectomy). A cosmetic service may, under certain circumstances, be considered restorative in nature. In order for Benefits to be available for such restorative surgery, the service must be necessary to correct a loss of physical function or alleviate significant pain; or, must be necessary due to a malappearance or deformity that was caused by physical trauma, surgery or congenital anomaly and the proposed surgery or treatment must be Preauthorized;
4. Inpatient care and related Physician Services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Covered Member's medical condition alone required Admission;
5. Services, supplies or drugs that are Experimental and Investigational;

6. Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services, supplies, treatment or medication for the management of Morbid Obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Physician or the passage of time from a Covered Member's obesity-related treatment. This includes the reversal of obesity-related treatments, and reconstructive procedures necessitated by weight loss. Membership fees to weight control programs;
7. Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities, unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits and specified in the section entitled "Definitions and Coverage Requirements";
8. Illness contracted or injury sustained as a result of a Covered Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service;
9. Any Medical Supplies or services rendered by a Covered Member to him or herself or rendered by a Covered Member's immediate family (parent, Child, spouse, brother, sister, grandparent or in-law);
10. Any charges for Medical Supplies or services rendered to the Covered Member prior to the Covered Member's effective date, the Employer's effective date, or after the Covered Member's coverage terminates, except as provided in the sections entitled "Termination of this Plan of Benefits" and "ERISA Rights";
11. Any service or charge for a service to the extent that the Covered Member is entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs;
12. Any Medical Supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Covered Member's sex;
13. Complications arising from a Covered Member's receipt or use of either services or Medical Supplies or other treatment that are not Benefits, including complications arising from a Covered Member's use of Discount Services;
14. Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Covered Member's use of Discount Services. Discount Services are not covered under the Plan of Benefits and Covered Members must pay for Discounted Services;
15. Services, supplies or Prescription Drugs related to any treatment for infertility, including but not limited to: fertility drugs; gynecological or urological procedures the purpose of which is primarily to treat infertility; artificial insemination; in-vitro fertilization; reversal of sterilization procedures and surrogate parenting;
16. Services, supplies or Prescription Drugs related to any treatment for impotence, including but not limited to penile implants;
17. Relationship counseling, including marriage counseling, for the treatment of pre-marital, marital or relationship dysfunction;
18. Routine foot care such as paring of nails, calluses, or corns or treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), unless needed in treatment of a metabolic or peripheral-vascular disease;
19. Food supplements unless such food supplements are available by prescription only and are prescribed by a Physician and are not used for weight control or loss;

20. Travel, whether or not recommended by a Physician, unless directly related to human organ or tissue transplants as specified on the Schedule of Benefits and when Preauthorized;
21. Durable Medical Equipment (DME) with a purchase or total rental price of $500 or more, when the required Preauthorization is not obtained;
22. Any service, supply, or charge the Covered Member is not legally obligated to pay;
23. Eyeglasses or contact lenses (except after cataract surgery) of any type, even though dispensed by a prescription;
24. Hearing aids and examination for the prescription or fitting thereof;
25. Hospital or Physician charges related to refractive care, except as specified on the Schedule of Benefits;
26. Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists;
27. Medical Supplies or services or charges for the diagnosis or treatment of sexual and gender identity disorders, personality disorders, learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, mental retardation or vocational Rehabilitation;
28. Well Baby Care/Well Child Care (routine care after the initial exam of a newborn baby), except as specified on the Schedule of Benefits;
29. A 50% penalty of the Allowable Charges in a Hospital or Skilled Nursing Facility when the required Preadmission Review, Emergency Admission Review and/or Continued Stay Review are not obtained;
30. Any dental procedures involving tooth structures, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin; provided, however, that such procedures may be covered if the need for dental services results from an accidental injury to Natural Teeth within one (1) year prior to the date of such services;
31. A 50% penalty of the Allowable Charges for Home Health Care or Hospice Care when the required Preapproval is not obtained;
32. Substance Abuse Services;
33. Illness contracted or injury sustained as a result of participating in a riot or insurrection, or while engaged in the commission of a felony or an illegal occupation;
34. Any surgical procedure relating to the eye other than one that is a result of trauma or disease. This includes, but is not limited to, radial keratotomy; any other procedure to correct refractive disorders not a consequence of trauma, or disease; or repair of prior ophthalmic surgery unless original surgery was a Covered Expense under this Plan;
35. Your covered Dependent Child's pregnancy, including childbirth;
36. Specialty Drugs are excluded under the Prescription Drug Benefit, except as specified on the Schedule of Benefits;
37. Acupuncture treatment or services;
38. Any service or charge for service to the extent a Covered Member is entitled to receive payment or Benefits (whether or not any such payment or Benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, or any state or political subdivision thereof. This exclusion includes but is not limited to benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal Hospital services for which the Covered Member is not legally obligated to pay;
39. This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Covered Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any

Workers' Compensation Act or similar law is required or is otherwise available for the Covered Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Covered Member but the Covered Member or Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or, the Covered Member sought treatment for the injury or illness from a Provider which is not authorized by the Covered Member's Employer or Workers' Compensation Carrier. If the Plan pays benefits for an injury or illness and the Plan determines the Covered Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Plan shall have the right of recovery as outlined in the section entitled "Workers' Compensation Provision";

40. Services which are initiated by either a Covered Member or Provider (including, but not limited to a Physician) in which the method of communication is not secure, does not occur in real-time, does not allow for an actual examination, or does not utilize both audio and video communication;
41. Services where a Covered Member transmits, whether by facsimile, e-mail, telephone or any other format, his or her specific health date (e.g. blood pressure, weight, etc.) to a Provider;
42. Charges by a Physician for blood and blood derivatives;
43. Fees for copying or production of medical records and/or claims filing;
44. Services or supplies relating to lifestyle improvements including, but not limited to, nutrition counseling or physical fitness programs;
45. Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or payable to a trainer of any type;
46. Charges for a Covered Member's appointment with a Provider that the Covered Member did not attend;
47. Chronic pain management programs or multi-disciplinary pain management programs unless Medically Necessary;
48. All Admissions solely for Physical Therapy, except as provided in the section entitled "Definitions and Coverage Requirements" for Rehabilitation Benefits;
49. Charges for services, supplies or fees for pre-marital or pre-employment examinations;
50. Charges for pre-operative anesthesia consultation;
51. Medical Supplies or services or other items not specifically listed as a Benefit in the section entitled "Definitions and Coverage Requirements" of this Plan of Benefits, on the Schedule of Benefits or as the law requires;
52. Any service, Medical Supplies, charges or losses resulting from a Covered Member being intoxicated or under the influence of any drug or other substance; abusing alcohol, drugs, or other substance; or, taking some action the purpose of which is to create a euphoric state or alter consciousness, unless taken on the advice of a Physician;
53. Lenses that do not require a prescription, except for balance lenses, except as specified on the Schedule of Benefits;
54. Prescription sunglasses, antireflective glasses, contact lenses or lenses to the extent the charge exceeds the amount allowed for regular lenses, except as specified on the Schedule of Benefits;

55. Replacement of lost, stolen or broken lenses or frames, except as specified on the Schedule of Benefits;
56. Drugs and medication administered for the purpose of or during an eye examination, except as specified on the Schedule of Benefits;
57. Visual training or aids; subnormal vision aids; orthoptics; aniseikonic lenses; tonometry, unless part of an eye examination, except as specified on the Schedule of Benefits;
58. Lenses or frames ordered while a Covered Member is eligible for coverage under this Plan of Benefits but delivered more than thirty (30) days after such coverage is terminated, except as specified on the Schedule of Benefits;
59. Charges for completion of vision care claim forms, except as specified on the Schedule of Benefits;
60. Any Medical Supply or service rendered to a Covered Member for vision care, except as specified on the Schedule of Benefits;
61. Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed in the section entitled "Definitions and Coverage Requirements";
62. Bio-feedback when related to psychological services;
63. Counseling and psychotherapy including, but not limited to, feeding and eating disorders in early childhood and infancy, tic disorders except when related to Tourette's disorder, elimination disorders, mental disorders due to a general medical condition, sexual function disorders, sleep disorders, medication induced movement disorders or nicotine dependence, except as specified on the Schedule of Benefits;
64. Vision therapy, except as specified on the Schedule of Benefits;
65. Hair loss. Care or treatment for hair loss including Wigs, hair transplants or nay drug that promises hair growth, whether or not prescribed by a Physician, except for Wigs after chemotherapy up to the limit shown in the Schedule of Benefits;.
66. Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language, and social skills modification, including: applied behavioral analysis therapy, Teaching Expanding Appreciating Collaborating and Holistic (TEACCH) programs, Higashi schools/daily life, facilitated communication, floor time; Developmental Individual-Difference Relationship-based model (DIR), Relationship Development Intervention (RDI), holding therapy, movement therapies, music therapy; and animal assisted therapy.
67. Abortion. Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued pregnancy.
68. Smoking cessation programs. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lunch illness such as emphysema or asthma.

PRESCRIPTION DRUG EXCLUSIONS

(Whether administered by the Corporation or by Caremark)

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN OF BENEFITS. THE ONLY EXCEPTIONS TO THIS ARE AS FOLLOWS: (1) WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED (UP TO THE CORRESPONDING DOLLAR AMOUNT AND/OR COVERAGE PERCENTAGE) IN THE SCHEDULE OF BENEFITS OR IN THE SECTION ENTITLED "DEFINITIONS AND COVERAGE REQUIREMENTS", OR (2) SERVICES RENDERED BY A HEALTH CARE PROVIDER AS PART OF A PHYSICIAN INCENTIVE PROGRAM (E.G. PATIENT-CENTERED MEDICAL HOME PROGRAM), AN ACCOUNTABLE CARE ORGANIZATION OR EPISODE-BASED ARRANGEMENT OR (3) AS THE LAW REQUIRES (I.E. INTENTIONAL OR UNREASONABLE INJURIES OR ILLNESSES THAT RESULT FROM MEDICAL CONDITIONS OR DOMESTIC VIOLENCE). SUBJECT TO THE ABOVE-LISTED EXCEPTIONS, THE EMPLOYER'S GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

1. Prescription Drugs used for weight control, obesity, cosmetic purposes, tobacco cessation, hair growth, infertility or impotence (but not limited to fertility drugs), except as specified on the Schedule of Benefits;
2. Unless otherwise set forth on the Schedule of Benefits, Medical Supplies, services or devices or Prescription Drugs of any type even though dispensed by a prescription, for the purpose of contraception;
3. Immunosuppressant drugs prescribed for an organ and/or tissue transplant. Applicable Benefits are payable under the human organ and tissue transplant Benefit;
4. Charges for Prescription Drugs or Specialty Drugs that are provided by a Physician but not consumed or administered in a Physician's office;
5. Drugs that are available on an Over-the-Counter basis or otherwise available without a prescription;
6. Prescription refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
7. Devices of any type, even those dispensed through a prescription, such as, but not limited to: contraceptive devices, therapeutic devices, artificial appliances or similar devices, except as specified on the Schedule of Benefits;
8. Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
9. Prescription Drugs for which there is an Over-the-Counter Drug equivalent and over-the-counter supplies and supplements;
10. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for a specific medical condition that has at least two (2) formal clinical studies or Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);

11. Any type of service, or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
12. Any Prescription Drug that is not consistent with the diagnosis and treatment of a Covered Member's illness, injury or condition; or is excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;
13. Prescription Drugs or services that require Preauthorization by the Corporation and Preauthorization is not obtained;
14. Prescription Drugs for injury or disease paid by workers' compensation Benefits (if a workers' compensation claim is settled, it will be considered paid by workers' compensation Benefits);
15. Prescription Drugs that are not Medically Necessary;
16. Prescription Drugs that are not authorized when a part of a Step Therapy program;
17. Medical Supplies, services or Prescription Drugs for treatment for tobacco cessation, except as specified in the Plan of Benefits;
18. Charges for Prescription Drugs that have not been prescribed by a Physician; Any vitamins except for prenatal vitamins; Prescription Drugs not approved by the Food and Drug Administration;
19. Prescription Drugs for non-covered therapies, services, or conditions;
20. Prescription Drugs administered, dispensed or bought at a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated.

DEFINITIONS AND COVERAGE REQUIREMENTS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

Because health coverage is sometimes hard to understand, the following information is provided to help Covered Members understand this health coverage Plan.

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. The Corporation pays the percentage of Allowable Charges for Covered Expenses as indicated on the Schedule of Benefits. Covered Expenses will only be paid for Benefits:

- Performed or provided on or after the Covered Member Effective Date; and,
- Performed or provided prior to termination of coverage; and,
- Provided by a Provider, within the scope of his or her license; and,
- For which the appropriate Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from the Corporation; and,
- That are Medically Necessary; and,
- That are not subject to an exclusion under the sections entitled "Medical Exclusions" and/or "Prescription Drug Exclusions" of this Plan of Benefits; and,
- After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

Payment for Covered Expenses may not be assigned to Non-Participating Providers.

If all of the following requirements are met, the Employer's Group Health Plan will provide the Benefits described in this "Definitions and Coverage Requirements" Section:

- All of the requirements in this section entitled "Definitions and Coverage Requirements" must be met; and,
- The Benefit must be listed in this section entitled "Definitions and Coverage Requirements"; and,
- The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,
- The Benefit must not be subject to one or more of the exclusions set forth in the sections entitled "Medical Exclusions" and/or "Prescription Drug Exclusions".

Actively at Work
A term describing all permanent, full-time Employees working at least thirty (30) hours a week. A term describing grandfathered Employees working at least twenty (20) hours a week. To qualify, you can't be absent from work during the initial enrollment period, because of a leave of absence or temporary lay-off, unless the absence is due to a Health Status-Related Factor.

Admission
The period of time between a Covered Member's Admission as a patient into a Hospital or Skilled Nursing Facility and the time the Covered Member leaves or is discharged.

Adverse Benefit Determination
Any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Experimental and Investigational or not Medically Necessary or appropriate.

Allergy Injections
The Employer's Group Health Plan will pay Covered Expenses for Allergy Injections as set forth below:

- For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,
- To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) doses; and,
- When any of the following conditions are met:

    - The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen; or,
    - The patient has a life threatening allergy to insect stings or food; or,
    - The patient has skin test and/or serologic evidence of a potent extract of the antigen; or,
    - Avoidance or pharmacological (drug) therapy cannot control allergic symptoms.

Allowable Charge
The amount the Corporation or a member of the Blue Cross and Blue Shield Association agrees to pay a Participating Provider or Non-Participating Provider as payment in full for a service, procedure, supply or equipment. For a Non-Participating Provider, (i) the Allowable Charge shall not exceed the Maximum Payment and (ii) in addition to the Covered Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Covered Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed charges.

Alternate Recipient
Any Child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

Ambulance Service
The Employer's Group Health Plan will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:

- Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition; and,
- To or from a Hospital in connection with an Admission.

Ambulatory Surgical Center
A licensed facility that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- Provides treatment by or under the supervision of medical doctors or oral surgeons and provides nursing services when the Covered Member is in the facility;
- Does not provide inpatient accommodations; and,
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a medical doctor or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

Benefit Year
The period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible
The amount, if any, listed on the Schedule of Benefits that must be paid by the Covered Member each Benefit Year before the Employer's Group Health Plan will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Covered Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefit(s)
Medical services or Medical Supplies that are:

- Medically Necessary; and,
- Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits); and,
- Included in this Plan of Benefits; and,
- Not limited or excluded under the terms of this Plan of Benefits.

Benefits available under this Plan of Benefits are listed in this section entitled "Definitions and Coverage Requirements".

Billed Charges
The actual charges as billed by a Provider.

BlueCard Program
A program in which all Covered Members of the BCBSA participate. Details of the BlueCard Program are more fully set forth in the section entitled 'BlueCard Program'.

Certificate of Creditable Coverage
A document from a Group Health Plan or insurer that states that a Covered Member had prior Creditable Coverage with that Group Health Plan or insurer. A certificate should be provided to you after your prior health insurance coverage is terminated. By presenting a certificate when you enroll for new health coverage, you may reduce the length of any Pre-Existing Condition Exclusion Period under your new health Plan.

Child
An Employee's Child, whether a natural Child, adopted Child, foster Child, stepchild, or Child for whom an Employee has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, a Child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. The term "Child" does not include the spouse of an eligible Child.

Chiropractic Services
If specifically included on the Schedule of Benefits, the Employer's Group Health Plan will pay Covered Expenses for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Cleft Lip or Palate
The Employer's Group Health Plan will pay Covered Expenses for the care and treatment of a congenital Cleft Lip or Palate, or both, and any physical condition or illness that is related to or developed as a result of a Cleft Lip or Palate.

Benefits shall include, but not be limited to:

- Oral and facial Surgical Services, surgical management and follow-up care; and,
- Prosthetic Device treatment such as obdurators, speech appliances and feeding appliances; and,
- Orthodontic treatment and management; and,
- Prosthodontia treatment and management; and,
- Otolaryngology treatment and management; and,
- Audiological assessment, treatment, and management, including surgically implanted amplification devices; and,
- Physical Therapy assessment and treatment.

Benefits for Cleft Lip or Palate must be Preauthorized. If a Covered Member with a Cleft Lip or Palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Employer's Group Health Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of the Employer's Group Health Plan.

Coinsurance
Coinsurance is the sharing of Covered Expenses between the Covered Member and the Employer's Group Health Plan. After the Covered Member's Benefit Year Deductible requirement is met, the Employer's Group Health Plan will pay the percentage of the Allowable Charges as set forth on the Schedule of Benefits. The Covered Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Covered Member calculated as follows:

- The percentage listed on the Schedule of Benefits; multiplied by,
- The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale;
- Without regard to any credit or allowance that may be received by the Corporation.

NOTE: Coinsurance responsibility limits do not include the Benefit Year Deductible, Hospital per Admission Copayment, emergency room per visit Copayment, Physician's Copayment, any charges in excess of the Allowable Charge, or Prescription Drug Copayment.

Companion Benefit Alternatives (CBA)
"Companion Benefit Alternatives (CBA)" is a behavioral health care company. CBA is responsible for managing behavioral health care services, including Pre-Certifying Mental Health Benefits for inpatient and outpatient services.

Concurrent Care Claim
An ongoing course of treatment to be provided over a period of time or number of treatments.

Continued Stay Review
The review that must be obtained by a Covered Member (or the Covered Member's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary. The Continued Stay Review process is outlined in the section entitled "Health Care Services".

Copayment
A Copayment is the dollar amount required to be paid to a health care Provider by a Covered Member at the time certain covered services are rendered by that Provider.

Corporation
Blue Cross and Blue Shield of Louisiana (Blue Cross).

Covered Expenses
The amount payable by the Employer's Group Health Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Covered Member
An Employee or Dependent who has enrolled under this Plan of Benefits.

Creditable Coverage
Benefits or coverage provided under any of the following (each capitalized term as defined under HIPAA unless defined in this Plan of Benefits):

- A Group Health Plan; or,
- Health insurance coverage; or,
- Part A or Part B, Title XVIII of the Social Security Act (Medicare); or,
- Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; or,
- Chapter 55 of Title 10, United States Code (Armed Forces, Medical and Dental Care); or,
- A medical care program of the Indian Health Service or of a tribal organization; or,
- A state health benefits risk pool; or,
- A health Plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Plan); or,
- A public health Plan, including that of the United States Federal Government as well as that of a foreign country or its political subdivision; or,
- A health benefit Plan under Section 5(e) of 22 U.S.C. 2504(e) (Peace Corps Act); or,
- A State Children's Health Insurance Program (S-CHIP).

This term "Creditable Coverage" does not include coverage consisting solely of Excepted Benefits.

Custodial Care
Non-skilled services that are primarily for the purpose of assisting an individual with daily living activities or personal needs (e.g. bathing, dressing, eating), which is not specific therapy for any illness or injury.

Dental Care for Accidental Injury
The Employer's Group Health Plan will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Covered Expenses will be paid for injuries that occur while the Covered Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Preauthorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.

Dependent(s)
An individual who is:

- An Employee's spouse; or
- A Child under the age set forth on the Schedule of Benefits; or
- An Incapacitated Dependent.

Diabetes Education
The Employer's Group Health Plan will pay Covered Expenses for outpatient self-management training and education for Covered Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

Discounted Services
From time to time Benefits in the form of discounts for certain Provider services or products will be provided to Covered Members by networks of complementary health care Providers with which the Administrator has an agreement for various programs. **This discount applies to services the health Plan does not cover.** The Corporation will not be responsible for any costs associated with these programs. The services available may include, but are not limited to: chiropractors, massage therapists, acupuncturists, fitness clubs and Hearing aids.

To find a participating network Hearing aid Provider in your area, call 1-800-235-8663. To find any other participating network Provider in your area for the services listed above, you may call 1-877-327-2746 or you may check the Corporation's website for a list of participating network Providers. You only need to show your ID card when you receive the service. The discount will be given to you at that time and there will be no claims to be filed.

Disease Management Program
The Disease Management Program is provided as part of the Employer's Group Health Plan. The Disease Management Program offers Covered Members the opportunity to better understand and address their diagnosed conditions as well as other ancillary products or services depending on the nature of the condition.

The Employer's Group Health Plan will offer Covered Members who have an appropriate diagnosis the option to participate in the Employer's Group Health Plan Disease Management Program. A Covered Member's participation in the Disease Management Program is voluntary.

Durable Medical Equipment (DME)
Durable Medical Equipment is medical equipment that:

- Can withstand repeated use; and,
- Is Medically Necessary; and,
- Is customarily used for the treatment of a Covered Member's illness, injury, disease or disorder; and,
- Is appropriate for use in the home; and,
- Is not useful to a Covered Member in the absence of illness or injury; and,
- Does not include appliances that are provided solely for the Covered Member's comfort or convenience; and,

- Is ordered by a medical doctor, oral surgeon, podiatrist, or osteopath; and,
- Is a standard, non-luxury item (as determined by the Employer's Group Health Plan).

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment.

The Employer's Group Health Plan will pay Covered Expenses for Durable Medical Equipment when the required Preauthorization is obtained. The Employer's Group Health Plan will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Employer's Group Health Plan will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Covered Member in a Hospital or that the Employer's Group Health Plan determines (in its sole discretion) is included in any Hospital room charge.

Emergency Admission Review
The review that must be obtained by a Covered Member (or the Covered Member's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition. The Emergency Admission Review process is outlined in the "Health Care Services" section.

Emergency Medical Care
Benefits that are provided in a Hospital emergency facility to evaluate and treat an Emergency Medical Condition.

The Employer's Group Health Plan will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Member, or with respect to a pregnant Covered Member, the health of the Covered Member or her unborn Child, in serious jeopardy; or,
- Serious impairment to bodily functions; or,
- Serious dysfunction of any bodily organ or part.

Employee
Any Employee of the Employer who is eligible for coverage, as provided in the section entitled "Eligibility Requirements" of this Plan of Benefits, and who is so designated to the Corporation by the Employer.

Employer
The entity providing this Plan of Benefits.

Employer's Effective Date
The date the Corporation begins to provide services under this Plan of Benefits.

Employer's Group Health Plan
The Group Health Plan adopted by the Employer as the Plan Sponsor. This Plan of Benefits outlines certain terms of the Employer's Group Health Plan.

ERISA
The Employee Retirement Income Security Act of 1974, and any amendments thereto.

Excepted Benefits
For purpose of HIPAA, the following insurance coverage does not constitute Creditable Coverage:

- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
- If offered separately:
  - Limited scope dental or vision benefits;
  - Benefits for long-term care, nursing home care, Home Health Care, community-based care, or any combination thereof;
  - Such other similar, limited benefits as are specified in regulations;
- If offered as independent, non-coordinated benefits:
  - Coverage only for a specified disease or illness;
  - Hospital indemnity or other fixed indemnity insurance;
- If offered as a separate insurance policy:
  - Medicare supplemental health insurance (as defined under Section 1882(g)(l) of the Social Security Act);
  - Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;
  - Similar supplemental coverage under a Group Health Plan.

Experimental and Investigational
Surgical procedures or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgment of the Corporation not recognized as conforming to generally accepted medical practice, or the procedure, drug or device:

- Has not received required final approval to market from appropriate government bodies; or,
- Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes; or,
- Is not demonstrated to be as beneficial as established alternatives; or,
- Has not been demonstrated to improve net health outcomes; or,
- Is one in which the improvement claimed is not demonstrated to be obtainable outside the Experimental and Investigational setting.

Genetic Information
Information about genes, gene products, (messenger RNA and transplanted protein), or genetic characteristics derived from an individual or family member of the individual. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements; chemical, blood, and urine analysis, unless conducted purposely to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of the human immunodeficiency virus.

Group Health Plan
An Employee welfare benefit Plan to the extent that such Plan provides health benefits to Employees or their Dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement, or otherwise. This Plan of Benefits is a Group Health Plan.

Gynecological Examination
The Employer's Group Health Plan will pay Covered Expenses for routine Gynecological Examinations each Benefit Year for female Covered Members.

Health Status-Related Factor
Information about a Covered Member's health, including:

- Health status;
- Medical conditions (including both physical and mental illnesses);
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic Information;
- Evidence of insurability (including conditions arising out of acts of domestic violence); or,
- Disability.

HIPAA
The Health Insurance Portability and Accountability Act of 1996, and any amendments and regulations thereto.

Home Health Agency
An agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care
Part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Covered Member in such Covered Member's private residence.

The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Home Health Care, including private duty nursing, when rendered to a homebound Covered Member in the Covered Member's current place of residence.

Hospice Care
Care for terminally ill patients under the supervision of a Physician, and is provided by an agency that is licensed or certified as a hospice or Hospice Care agency by the appropriate state regulatory agency.

The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Hospice Care provided in an outpatient setting.

Hospital
A short-term, acute care facility licensed as a Hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Physicians, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Covered Members.

The Employer's Group Health Plan will pay Covered Expenses for Admissions as follows:

- Semiprivate room, board, and general nursing care; and,
- Private room, at semiprivate rate as determined by the Employer's Group Health Plan; and,
- Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital; and,
- Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms; and,
- Diagnosis services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,
- In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Covered Member leaves a Hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Covered Member returns to the Hospital by midnight of the same day. The day a Covered Member enters a Hospital is treated as a day of Admission. The days during which a Covered Member is not physically present for inpatient care are not counted as Admission days.

Human Organ Transplant Coverage

The Employer's Group Health Plan will pay Covered Expenses for certain Preauthorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Covered Member, and provided at a transplant center approved by the Employer's Group Health Plan. Covered Expenses shall only be provided for the human organ and tissue transplants in the amounts set forth on the Schedule of Benefits.

These services must be preapproved and performed at a Provider approved by BlueCross BlueShield. If these services are not preapproved and performed by a Provider approved by the Employer's Group Health Plan, inpatient penalties may apply. The Employer's Group Health Plan will pay Covered Expenses for the following transplants:

Kidney (single)
Kidney (double)
Pancreas
Pancreas and Kidney
Heart
Lung (single)
Lung/ Segmental Lung (double)
Heart and Lung (single)
Heart and Lung (double)
Liver/ Segmental Liver
Bone Marrow/Stem Cell
Cornea

For Preapproval and information about any type of transplant recommended for the Covered Member, call the Corporation's Health Care Services (HCS) department. The telephone number for Health Care Services is 1-888-376-6544.

The payment of Covered Expenses for living donor transplants will be subject to the following conditions:

- When both the transplant recipient and the donor are Covered Members, Covered Expenses will be paid for both.
- When the transplant recipient is a Covered Member and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.
- When the donor is a Covered Member and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.

Benefits for human organ and tissue transplants may be subject to the Benefit Year Deductible amount and will be provided according to the percentage and/or dollar maximum specified on the Schedule of Benefits.

Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and Outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.

Transplants of tissue as set forth in this paragraph (rather than whole major organs) are Benefits under the Employer's Group Health Plan, subject to all of the provisions of the Employer's Group Health Plan as follows:

- Blood transfusions; and,
- Autologous parathyroid transplants; and,
- Corneal transplants; and,
- Bone and cartilage grafting; and,
- Skin grafting.

Identification Card
The card issued by the Corporation to a Covered Member that contains the Covered Member's identification number.

Impacted Tooth Removal
The Employer's Group Health Plan will pay Covered Expenses for services and Medical Supplies for the removal of impacted teeth.

Incapacitated Dependent
A Child who is incapable of financial self-sufficiency by reason of a disabling mental or physical handicap and who is legally dependent upon the Employee for at least fifty-one percent (51%) of support and maintenance.

A Child must meet these requirements to qualify as an Incapacitated Dependent. The Employee will furnish written proof no later than thirty-one (31) days prior to the Dependent's reaching twenty-six (26) years of age. A Child who is not incapacitated by the maximum Dependent Child age listed in the section entitled "Definitions and Coverage Requirements" will not be covered. The Employee will update these requirements upon the Corporation's request.

In-Hospital Medical Service
The Employer's Group Health Plan will pay Covered Expenses for Physician's visits to a Covered Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

- In-hospital medical Benefits primarily for Mental Health Services; and,

- In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits.

- Where two (2) or more Physicians render In-Hospital Medical Service on the same day, payment for such services will be made only to one (1) Physician.

- Concurrent medical and surgical Benefits for In-Hospital Medical Services are only provided:

- When the condition for which In-Hospital Medical Services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant; and,

- When the surgical procedure performed is designated by the Employer's Group Health Plan as a warranted diagnostic procedure or as a minor surgical procedure.

- When the same Physician renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

Long-Term Acute Care Hospital

Means a long-term, acute care facility licensed as a long term care Hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Covered Members (typically over an extended period of time) although such Covered Members may no longer need general acute care typically provided in the Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Covered Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Long-Term Acute Care Hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Covered Members.

Mammography Testing

The Employer's Group Health Plan will pay Covered Expenses for one (1) mammography test per Benefit Year regardless of Medical Necessity for female Covered Members that are within the appropriate age guidelines. The Employer's Group Health Plan will pay Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

Maximum Payment

The maximum amount the Employer's Group Health Plan will pay (as determined by the Corporation) for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion:

- The actual charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider; or
- An amount based upon the reimbursement rates established by the Plan Sponsor in its benefits checklist; or
- An amount that has been agreed upon in writing by a Provider and the Corporation or a member of the BCBSA; or
- An amount established by the Corporation, based upon factors including, but not limited to, (i) governmental reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or

- The lowest amount of reimbursement the Corporation allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

Medical Child Support Order
Any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

- Provides Child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits; or,
- Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.
- A Medical Child Support Order must clearly specify:
  - The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order; and,
  - A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined; and,
  - The period to which such order applies; and,
  - Each Group Health Plan to which such order applies.
- If the Medical Child Support Order is a national medical support notice, the order must also include:
  - The name of the issuing agency; and,
  - The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,
  - The identification of the underlying Medical Child Support Order.
- A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medical Supplies
Means supplies that are:

- Medically Necessary; and,
- Prescribed by a Physician acting within the scope of his or her license (or are provided to a Covered Member in a Physician's office); and,
- Are not available on an over-the-counter basis (unless such supplies are provided to a Covered Member in a Physician's office and should not (in the Corporation's sole discretion) be included as part of the treatment received by the Covered Member); and,
- Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

The Employer's Group Health Plan will pay Covered Expenses for Medical Supplies; provided, however that the Employer's Group Health Plan will not pay Covered Expenses separately for Medical Supplies that are (or in the Employer's Group Health Plan's determination, should be) provided as part of another Benefit.

Medically Necessary or Medical Necessity
Means health care services that a Physician, 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 generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally 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 Effective Date
The date on which an Employee or Dependent is covered for Benefits under the terms of the section entitled "Eligibility Requirements" of this Plan of Benefits.

Membership Application
Any mechanism agreed upon by the Corporation and the Employer for transmitting necessary Covered Member enrollment information from the Employer to the Corporation.

Mental Health Services
Treatment (except Substance Abuse Services) that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

The Employer's Group Health Plan will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services.

Morbid Obesity
Is when a Covered Member has a body mass index of forty (40) or greater, or there is a body mass index of thirty-five (35) or greater and complicating medical conditions such as hypertension, diabetes, obstructive sleep apnea, etc; and, such Covered Member has failed to consistently lose weight utilizing standard non-surgical weight loss programs.

Natural Teeth
Teeth that:

- Are free of active or chronic decay; and,
- Have at least fifty percent (50%) bone support; and,
- Are functional in the arch; and,
- Have not been excessively weakened by multiple dental procedures; or,

- Have been treated for one (1) or more of the conditions referenced in the bullets listed above, and as a result of such treatment have been restored to normal function.

Newborns' and Mothers' Health Protection Act

Under the terms of the Newborn and Mother's Health Act of 1996, the Employer's Group Health Plan generally may not restrict Covered Expenses for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Employer's Group Health Plan may not require that a Provider obtain authorization from the Employer's Group Health Plan for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Preauthorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

Non-Participating Provider (Non-Preferred/Non-PPO)

Any Provider who does not have a current, valid Provider Agreement with the Corporation or another member of the BCBSA, including any licensed Hospital, Physician, supplier, Pharmacy, Skilled Nursing Facility or Home Health Agency. Covered Members receiving health care services from Non-Participating Providers are responsible for filing claims in connection with those services and for payment of those services. **BCBS's payment, if any, may be made directly to the Covered Member and not the Provider.**

Please note that any payment made to a Non-Participating Provider will be subject to the Non-PPO Schedule of Benefits. The Provider, with the exception of Traditional Providers, may also collect from you the difference between the Allowable Charge and their charge (sometimes referred to as balance billing). This difference does not apply to Out-of-Pocket Expense limits. Charges exceeding the Allowable Charge will be the patient's responsibility.

Obesity Related Procedures

The Employer's Group Health Plan may pay Covered Expenses for the following: (See the Schedule of Benefits and Medical Exclusion sections for specific benefits).

Services, supplies, treatment or medication for the management of Morbid Obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment").

Obstetrical Coverage

Obstetrical services are those related to the state of pregnancy, including routine and complicated delivery and miscarriages. Benefits for Preauthorized obstetrical services are payable for female Employees and wives of Employees. Benefits are not payable for obstetrical services for a Dependent female Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Online Personal Health Assessment

The Employer's Group Health Plan will provide Covered Members with access to Online Personal Health Assessment survey that provides an individual risk score and wellness information. Please visit www.MyHealthToolkitLA.com.

Optician
A person who makes, fits, supplies and adjusts eyeglasses or lenses in accordance with a vision care prescription written by a Physician.

Orthognathic Surgery
The Employer's Group Health Plan will pay Covered Expenses for any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities for which the resulting disorder is breathing, nutritional or speech related. Services exclude dental conditions related to biting, chewing or teeth.

Orthopedic Devices
Any rigid or semi-rigid leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Orthopedic Devices.

Orthotic Devices
Any device used to mechanically assist, restrict, or control function of a moving part of the Covered Member's body.

The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Orthotic Devices that are not available on an over-the-counter basis and are not otherwise excluded under this Plan of Benefits.

Out-of-Pocket Maximum
The maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Covered Member will be required to pay. The Out-of-Pocket Maximum is Coinsurance payable by the Covered Member. Copayments and Benefit Year Deductibles may not apply toward the Out-of-Pocket Maximum (as set forth on the Schedule of Benefits).

Please note that Non-Participating Providers, with the exception of Traditional Providers, may also collect from you the difference between the Allowable Charge and their charge. This difference does not apply to Out-of-Pocket Maximum limits. Charges exceeding the Allowable Charge will be the patient's responsibility.

Outpatient Hospital and Ambulatory Surgical Center Services
The Employer's Group Health Plan will pay Covered Expenses for Surgical Services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an Outpatient Hospital setting or an Ambulatory Surgical Center.

Outpatient Rehabilitation Services
Subject to the following paragraph, the Employer's Group Health Plan will pay Covered Expenses for Physical Therapy, occupational therapy, speech therapy and Rehabilitation Services as set forth on the Schedule of Benefits.

Covered Expenses for Outpatient Rehabilitation Services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

Over-the-Counter Drug
A drug that does not require a prescription.

Oxygen
The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Oxygen. Durable Medical Equipment for Oxygen use in a Covered Member's home is covered under the Durable Medical Equipment Benefit.

Pap Smear
The Employer's Group Health Plan will pay Covered Expenses for a single Pap Smear as part of the annual Gynecological Examination Benefit without regard to Medical Necessity. The Employer's Group Health Plan will pay Covered Expenses for additional Pap Smears during a Benefit Year based on Medical Necessity. This Benefit covers the Physicians fee only. Pap Smears for other than routine purposes will be paid as outpatient diagnostic services subject to the Benefit Year Deductible and Coinsurance (where applicable).

Participating Pharmacy
A Pharmacy that has a contract with the Corporation, Employer or with the Pharmacy Benefit Manager to provide Prescription Drugs or Specialty Drugs to Covered Members.

Participating Provider (Preferred/PPO)
A Provider who has a current, valid Provider Agreement.

Participating Provider Schedule of Allowances (PPO Allowance)
The amount allowed for Covered Expenses when received from Participating Providers other than Hospitals and Skilled Nursing Facilities is the Participating Provider Schedule of Allowances. These allowances are agreed to by Participating Providers and the Corporation.

The amount allowed for Covered Expenses received from Hospitals and Skilled Nursing Facilities are Allowable Charges.

Pharmacy
Any commercial establishment where the profession of Pharmacy is practiced, except for a Physician's office or for a Pharmacy affiliated with or part of a Hospital, Skilled Nursing Facility or other similar type of institution.

Pharmacy Benefit Manager
An entity who has contracted with the Employer or with the Corporation and is responsible for the administration of the Prescription Drug Benefit in accordance with the Employer's Group Health Plan.

PHI
Protected Health Information as that term is defined under "GENERAL PROVISIONS".

Physical Therapy
The Employer's Group Health Plan will pay Covered Expenses for Physical Therapy as set forth on the Schedule of Benefits.

Physician
A person who is:

- Not an:
  - Intern; or,
  - Resident; or,
  - In-house Physician; and,
- Duly licensed by the appropriate state regulatory agency as a:
  - Medical doctor; or,
  - Oral surgeon; or,
  - Osteopath; or,
  - Podiatrist; or,
  - Chiropractor; or,
  - Optometrist; or,
  - Ophthalmologist; or,
  - Psychologist with a doctoral degree in psychology; and,
- Legally entitled to practice within the scope of his or her license; and,
- Customarily bills for his or her services.

Physician Services
The following services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by the Corporation:

- Office visits, which are for the purpose of seeking or receiving care for an illness or injury; or,
- Basic diagnostic services and machine tests;
- Physician Services includes the following services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:

  - Benefits rendered to a Covered Member in a Hospital or Skilled Nursing Facility; or,
  - Benefits rendered in a Covered Member's home; or,
  - Surgical Services; or,
  - Anesthesia services, including the administration of general or spinal block anesthesia; or,
  - Radiological examinations; or,
  - Laboratory tests; or,
  - Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also includes maternity services performed by certified nurse midwives.

The Employer's Group Health Plan will pay Covered Expenses for Physician Services; provided, however, that when different levels (as determined by the Employer's Group Health Plan) of Physician Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Employer's Group Health Plan) of Physician Services.

Plan
Any program that provides Benefits or services for medical or dental care or treatment including:

- Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and,
- Coverage under a governmental Plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in the section entitled "Coordination of Benefits" applies only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator
The entity charged with the administration of the Plan of Benefits. The Employer is the Plan Administrator of this Plan of Benefits.

Plan of Benefits
This Preferred Provider Plan of Benefits including, the Membership Application, the Schedule of Benefits, and all endorsements, amendments, riders, or addendums.

Plan of Benefits Effective Date
12:01 AM on the date listed on the Schedule of Benefits.

Plan Sponsor
The party sponsoring a Plan of Benefits. The Employer is the Plan Sponsor of the Employer's Group Health Plan.

Post-Service Claim
Any claim for a Benefit that is not a Pre-Service Claim.

Preadmission Review
The review that must be obtained by a Covered Member (or the Covered Member's representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in the section entitled "Health Care Services".

Preauthorization (also referred to as Preauthorized, Pre-Certification, Pre-Certified, Preadmission, or Preapproval)
The approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Covered Member. Preauthorization means only that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Covered Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Covered Member's eligibility, Pre-Existing Condition Limitations and all other limitations and exclusions contained in this Plan of Benefits. A Covered Member's entitlement to Benefits is not determined until the Covered Member's claim is processed. The Preauthorization process is outlined in the section entitled "Health Care Services".

Premium
The monthly amount paid to the Employer by the Covered Member for coverage under this Plan of Benefits. Payment of Premiums by the Covered Member constitutes acceptance by the Covered Member of the terms of this Plan of Benefits.

Prescription Drug
A drug or medicine that is:

- Required to be labeled that it has been approved by the Food and Drug Administration; and,
- Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner; or,
- Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

- Be ordered by a Physician as a prescription; and,
- Not be entirely consumed at the time and place where the prescription is dispensed; and,
- Be purchased for use outside a Hospital.

The Employer's Group Health Plan will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which Benefits are otherwise available. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any credits by the Employer's Group Health Plan. Copayments likewise do not change due to receipt of any credits by the Employer's Group Health Plan.

Insulin shall be treated as a Prescription Drug whether injectable or otherwise.

The Employer's Group Health Plan may, in its sole discretion, place quantity limits on Prescription Drugs.

Brand Name Drug
A Prescription Drug that is manufactured under a registered trade name or trademark.

Generic Drug
A Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or

trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

Retail Pharmacy
A prescription or refill purchased from a Participating Pharmacy will be subject to the applicable Copayments for each Generic or Brand drug purchased. Any prescription or refill purchased from a Non-Participating Pharmacy will not be covered. Only covered Prescription Drugs and diabetic supplies are eligible under these Benefits.

Financial credits (including rebates and/or other amounts) may be received by the Corporation directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager. Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Employer or Covered Members. Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these credits. Any Coinsurance that a Covered Member must pay for Prescription Drugs or Specialty Drugs is based upon the Allowable Charge at the Pharmacy, and does not change due to receipt of any credit by the Corporation. Copayments are not affected by any credit.

In order to receive full Benefits you must show your ID card and pay the applicable Copayment.

Prescription Drug Copayment
The amount payable, if any, set forth on the Schedule of Benefits, by the Covered Member for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible or the Out-of-Pocket Maximum.

Prescription Drug Preauthorization Program
Programs that prohibit patients from obtaining medications until approvals have been obtained.

Pre-Service Claim
Any request for a Benefit where Preauthorization must be obtained before receiving the medical care, service or supply.

Primary Plan
A Plan whose Benefits must be determined without taking into consideration the existence of another Plan.

Prostate Examination
The Employer's Group Health Plan will pay Covered Expenses for Prostate Examinations for male Covered Members. Prostate screenings for other than routine purposes will be paid as outpatient diagnostic services subject to the Benefit Year Deductible and Coinsurance (where applicable).

Prosthetic Devices
Any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

The Employer's Group Health Plan will only pay Covered Expenses for Prosthetic Devices when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Employer's Group Health Plan) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement, or when a change in the Covered Member's condition warrants replacement.

Provider
Any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity's license in the practice of any of the following:

- Medicine
- Dentistry
- Optometry
- Podiatry
- Chiropractic Services
- Behavioral Health
- Physical Therapy
- Oral Surgery
- Speech Therapy
- Occupational Therapy

The term Provider also includes a Hospital, a Rehabilitation Facility, a Skilled Nursing Facility and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives, or masseuses.

Provider Agreement
An agreement between the Corporation (or another member of the BCBSA) and a Provider under which the Provider has agreed to accept an allowance (as set forth in the Provider Agreement) as payment in full for Benefits and other mutually acceptable terms and conditions.

Qualified Medical Child Support Order
A Medical Child Support Order that:

- Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,
- Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event
For continuation of coverage purposes, a Qualifying Event is any one of the following:

- Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under the Plan of Benefits;
- Death of the Employee;
- Divorce or legal separation of the Employee from his or her spouse;
- A Child ceasing to qualify as a Dependent under this Plan of Benefits;
- Entitlement to Medicare by an Employee, or by a parent of a Child;
- A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Quantity versus Time (QVT) Limits
Limits that restrict access by limiting the amount of Prescription Drugs that are covered under a Covered Member's Benefit within a certain time frame. The limits established for these drugs are based on FDA approved indications.

Reconstructive Surgery following Mastectomies
In the case of a Covered Member who is receiving Covered Expenses in connection with a mastectomy, the Employer's Group Health Plan will pay Covered Expenses for each of the following (if requested by such Covered Member):

- Reconstruction of the breast on which the mastectomy has been performed; and,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
- Prosthetic Devices and physical complications at all stages of the mastectomy, including lymphedema.

In order to be covered, such surgery must be provided in a manner chosen by the Covered Member's Physician, consistent with prevailing medical standards, and in consultation with the Covered Member.

The Covered Member Plan's Benefit Year Deductible, applicable Copayment, and Coinsurance will apply.

Rehabilitation
The Employer's Group Health Plan will pay Covered Expenses for participation in a multidisciplinary team Rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

- All such treatment must be ordered by a medical doctor; and,
- All such treatment may require Preauthorization and must be performed by a Provider and at a location designated by the Employer's Group Health Plan; and,

- The documentation that accompanies a request for Rehabilitation Benefits must contain a detailed Covered Member evaluation from a medical doctor that documents that to a degree of medical certainty the Covered Member has Rehabilitation potential such that there is an expectation that the Covered Member will achieve an ability to provide self-care and perform activities of daily living; and,
- All such Rehabilitation Benefits are subject to periodic review by the Employer's Group Health Plan.

After the initial Rehabilitation period, continuation of Rehabilitation Benefits will require documentation that the Covered Member is making substantial progress and that there continues to be significant potential for the achievement of the established Rehabilitation goals.

Rehabilitation Facility
Licensed facility operated for the purpose of assisting Covered Members with neurological or other physical injuries to recover as much restoration of function as possible.

Restricted Annual Dollar Limit
Means the total Benefits (under this Group Health Plan) to which a Covered Member is entitled to each Benefit Year for essential health Benefits as defined under the Patient Protection and Affordable Care Act (PPACA). The restricted annual dollar limit is for Benefit Years beginning on or after September 23, 2010, but prior to January 1, 2014. Refer to the Schedule of Benefits for the Restricted Annual Dollar Limit.

Routine Annual Benefits
The Employer's Group Health Plan may offer certain Routine Annual Benefits (typically preventive care) as set forth on the Schedule of Benefits.

Routine Physical
One Routine Physical per Benefit Year for Covered Members is covered. Benefits are payable as specified on the Schedule of Benefits.

Schedule of Benefits
The pages of this Plan of Benefits so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Secondary Plan
A Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

Second Surgical Opinion
The medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed Physician of medicine has proposed to perform surgery, but before the surgery is performed. The second Physician must not be associated with the primary Physician.

Skilled Nursing Facility (SNF)
An institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a Skilled Nursing Facility.

The Employer's Group Health Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:

- Semiprivate room, board, and general nursing care;
- Private room, at semiprivate rate as determined by the Employer's Group Health Plan;
- Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;
- Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
- Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;
- In a Long-Term Acute Care Hospital.

Benefits for Admission are subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Covered Member leaves a Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Covered Member returns to the Skilled Nursing Facility by midnight of the same day. The day a Covered Member enters a Skilled Nursing Facility is treated as a day of Admission. The days during which a Covered Member is not physically present for inpatient care are not counted as Admission days.

Special Care Unit
A specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Covered Members requiring extraordinary care on a concentrated and continuous basis, such as burn, intensive, or coronary care units.

Special Enrollment
The time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in this section of the Plan of Benefits.

Specialist
A Physician that specializes in a particular branch of medicine.

Specialty Drugs
Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty drugs include, but are not limited to infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

The Employer's Group Health Plan will pay Covered Expenses for Specialty Drugs. Covered Expenses for Specialty Drugs dispensed to a Covered Member shall not exceed the quantity and Benefit maximum set by the Employer's Group Health Plan. Specialty Drugs may be considered medical Benefits. For any Specialty Drugs paid as medical Benefits the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply. The Covered Member may obtain a list of Specialty Drugs by contacting the Employer's Group Health Plan at the number listed on the Identification Card or at **www.MyHealthToolkitLA.com**.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any credits by the Employer's Group Health Plan. Copayments likewise do not change due to receipt of any credits by the Employer's Group Health Plan.

Step Therapy Program
Programs that require a Covered Member to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medications.

Substance Abuse
The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described, or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.)

Substance Abuse Services
Services or treatment relating to Substance Abuse.

Surgical Services
An operative or cutting procedure or the treatment of fractures or dislocations. Surgical Services include the usual, necessary and related pre-operative and post-operative care when performed by a medical doctor or oral surgeon.

The Employer's Group Health Plan will pay Covered Expenses for Surgical Services performed by a Physician for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

- Surgical Services, subject to the following:
    - If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.
    - If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.

- If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty percent (50%) for the procedure bearing the second and third highest Allowable Charges, twenty-five percent (25%) for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten percent (10%) for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty percent (50%) of the charge for each subsequent procedure.

- If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.

- If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be covered for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Employer's Group Health Plan when so requested by the medical doctor or oral surgeon in charge of the case.

- Certain surgical procedures are designated as separate procedures by the Employer's Group Health Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

- Surgical assistant services, that consists of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, or in-house Physician. The Employer's Group Health Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

- Anesthesia services, that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

Telemedicine

The exchange of member information from one eligible referring Provider ("Referring Physician") site to another eligible consulting Provider ("Consulting Physician") site for the purpose of providing medical care to a Covered Member in circumstances in which in person, face-to-face contact with the Consulting Physician is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

The Employer's Group Health Plan will pay Covered Expenses for certain Telemedicine services only if the Covered Member's access to appropriate specialty care is difficult, inaccessible or unavailable or in an urgent situation where access to the specialty care is needed immediately.

Consulting and Referring Physicians must be Participating Providers who have been credentialed as eligible Telemedicine Providers.

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services. Telemedicine services will be covered by the Employer's Group Health Plan when they are Covered Services under the terms of this Plan of Benefits and under the following circumstances:

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Covered Member's need; and
- The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

Examples of interactions that are not reimbursable Telemedicine (or telepsychiatry) services and will not be reimbursed are:

- Telephone conversations;
- E-mail messages;
- Video cell phone interactions;
- Facsimile transmissions;
- Services provided by allied health professionals that are neither allopathic or osteopathic Physicians;
- Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

Temporomandibular Joint (TMJ) Disorder

The Employer's Group Health Plan will pay Covered Expenses for any service for the treatment of dysfunctions or derangements of the temporomandibular joint, including Orthognathic Surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

Totally Disabled/Total Disability
Means that the Covered Member is able to perform none of the usual and customary duties of such Covered Member's occupation. With respect to a Covered Member who is a Dependent, the terms refer to disability to the extent that such Covered Member can perform none of the usual and customary duties or activities of a person in good health of the same age. The Covered Member must provide a Physician's statement of disability upon periodic request by the Employer's Group Health Plan.

Traditional Providers
Traditional Providers are those health care Providers who are not PPO Participating Providers, but who have entered into a contract with the local BlueCross BlueShield Plan to participate in their Traditional Program. These Providers have agreed to accept BCBS's allowance as payment in full for covered services. They have also agreed not to bill or otherwise collect from a Covered Member any amounts in excess of the BCBS allowance, except as otherwise permitted under the terms of the Schedule of Benefits and their Provider contract. **BCBS's payment, if any, for covered services rendered by a Traditional Provider will be subject to the Non-PPO Schedule of Benefits, and will always be made directly to the Provider.**

Urgent Care Claim
Any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Covered Member's life or health or the Covered Member's ability to regain maximum function; or, in the opinion of a medical doctor or oral surgeon with knowledge of the Covered Member's medical condition, would subject the Covered Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

USERRA
The Uniformed Services Employment and Re-employment Rights Act of 1994 including any amendments thereto.

Well Baby Care/Well Child Care
Care for Dependents. Benefits are payable as specified on the Schedule of Benefits.

HEALTH CARE SERVICES

Approval from BlueCross BlueShield

The Health Care Services program is designed to help ensure that all covered participants receive necessary and appropriate health care while avoiding unnecessary expenses by requiring Pre-Certification and utilization review of Hospital Admissions. Notification of all Hospital Admissions (including Admissions for treatment of mental health conditions) is ***required****. Certification and utilization review is handled by* **Health Care Services (HCS) and/or Companion Benefit Alternative (CBA)**. *Advance approval for all Admissions and certain other services must be acquired from the Corporation in order for maximum Benefits to be provided.*

Please understand that the Covered Member must obtain approval for those services or supplies that require Preapproval. (Refer to the Schedule of Benefits)

Preapproval in writing from HCS is required for all transplants. **Inpatient penalties may apply on transplants that are not preapproved in writing by the Claims Administrator.**

If the Physician recommends hospitalization for the Covered Member, make sure to tell the Physician that the health Plan requires Preapproval certification for all Admissions.

Where to Call for Approval

For Mental Health Services the Covered Member should contact Companion Benefit Alternatives (CBA), by calling the following number:

- 1-800-868-1032

For all other services that require Pre-Certification, the Covered Member should contact the Corporation for approval, by calling the Health Care Services (HCS) Department at the following number:

- 1-888-376-6544

These numbers are also shown on the BlueCross BlueShield ID Card.

When the Covered Member calls, they will talk with a nurse in HCS. The nurse will ask for the following information:

- Employee's name and ID number
- Patient's name and relationship to the Employee
- Physician's name, address and phone number
- Hospital or Skilled Nursing Facility's name, address and phone number
- Reason the patient needs care

The nurse will let the Covered Member, the Physician and the Hospital know whether the Admission is approved as Medically Necessary and for what length of time.

If the Covered Member cannot call for approval, an Authorized Representative may call for them. The Covered Member or Authorized Representative who calls should be able to give the necessary information to HCS.

In most cases, Participating Providers will coordinate obtaining Pre-Certification on the Covered Member's behalf; **however, it is the Covered Member's responsibility to ensure approvals are obtained.**

Approval calls should be made to Health Care Services. The Covered Member should not call the Customer Service Center. Customer Service personnel cannot give approval.

Important Note:

Approval from Health Care Services (HCS) means that a service is Medically Necessary for treatment of the patient's condition. HCS approval is not a guarantee or verification of Benefits. Payment of Benefits is subject to patient eligibility, Pre-Existing Condition Waiting Periods and all other Plan limitations and exclusions. Final Benefit determination will be made when claims are filed.

Types of Approval

There are four types of approval: Preadmission Review, Emergency Admission Review, Continued Stay Review, and Preauthorization Review. Each type of approval is explained below.

Preadmission Review (Pre-Certification)

Preadmission Review approval must be obtained by the Covered Member (or the Covered Member's representative) before being admitted to a Hospital or SNF for any non-Emergency Medical Conditions. Approval also is needed within twenty-four (24) hours of the mother's discharge if a newborn is sick and must remain in the Hospital. If approval is not obtained, or if the Admission is not approved but the Covered Member is still admitted, financial penalties may be assessed for failure to obtain Pre-Certification. **It is the Covered Member's responsibility to ensure the Pre-Certification is obtained.**

Emergency Admission Review (Pre-Certification)

An emergency is the sudden onset of an illness or injury. When the Covered Member has an emergency, the Corporation does not expect the Covered Member to wait for Preadmission Review approval before going to the Hospital.

However, except for reasons beyond the Covered Member's control, HCS must be notified:

- Within twenty-four (24) hours after the emergency Admission, or by close of business the next business day following the Admission.

If Emergency Admission Review approval is not obtained, financial penalties may be assessed for failure to obtain Pre-Certification. **It is your responsibility to ensure the Pre-Certification is obtained.**

Continued Stay Review (Pre-Certification)

If the Covered Member remains in the Hospital or SNF for a longer period than that approved by the Corporation, they must get Continued Stay Review approval from HCS.

If the Covered Member does not get Continued Stay Review approval, or if the continued stay is not approved but the Covered Member stays in the Hospital or SNF, financial penalties may be assessed for failure to obtain Pre-Certification. **It is your responsibility to ensure the Pre-Certification is obtained.**

Preauthorization Approval

Home Health Care, Hospice Care, and transplants require Preauthorization Review approval. **Preauthorization must be obtained or Benefits may be reduced.**

Preauthorization approval is also needed when the purchase or total rental price of Durable Medical Equipment is $500 or more.

If advance approval is not obtained, this Plan will not provide Benefits for any charges for DME. **If advance** approval is not obtained, 50% of the Allowable Charges will be denied for Home Health Care, Hospice Care or human organ and tissue transplant services. Preauthorization is also required for inpatient physical Rehabilitation. Financial penalties may be assessed for failure to obtain Pre-Certification.

Approval from HCS means that a service is Medically Necessary for treatment of the patient's condition. HCS approval is not a guarantee or verification of Benefits. Payment of Benefits is subject to patient eligibility, Pre-Existing Condition Waiting Periods and all other Plan limitations and exclusions. Final Benefit determination will be made when claims are filed.

For more information about services and supplies that require Preauthorization Review, please see the section entitled “Definitions And Coverage Requirements” of this booklet.

EXTENDED COVERAGE BENEFITS

If a covered employee ceases active employment. participation may be continued for a maximum of eighteen months, pursuant to procedures adopted by the Plan Administrator and applied on a basis uniformly applicable to all employees similarly situated.

Diocese of Lafayette Group Health Benefits Plan, administered by BlueCross BlueShield, provides the privilege for covered employees to request extended health insurance of up to a maximum of eighteen (18) months. immediately following the last day of the month for which the member was considered an Employee.

Continuation During Family and Medical Leave. The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of unpaid, job-protected leave during any 12 month period to eligible employees for certain family and medical reasons. These Plan provisions are intended to comply with the law and any pertinent regulations, and interpretation is governed by them. Please see the Plan Administrator for details of the FMLA policy adopted by the employer when you need to take FMLA leave.

Continuation of Coverage for Employees on Military Leave. Please refer to the Termination of Coverage
Section.

Covered participants pay the entire cost of the Extended Coverage Benefit for themselves and their dependents.

USERRA

In any case in which an Employee or any of such Employee's Dependent has coverage under the Plan of Benefits, and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this section. The maximum period of coverage of the Employee and such Employee's Dependent under such an election shall be the lesser of:

- The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or
- The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period..

An Employee who elects to continue coverage under this section of the Employer’s Group Health Plan must pay one hundred and two percent (102%) of such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.

An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Employer's Group Health Plan upon re-employment. Except as otherwise provided in the last paragraph of this section, upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion or Pre-Existing Condition Waiting Period would normally have been imposed. This applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under the Employer's Group Health Plan by reason of the reinstatement of the coverage of such Employee.

The program above shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Employer's Group Health Plan shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

- Procedural Requirements
  - Timely Notifications and Determinations

    In the case of any Medical Child Support Order received by the Employer's Group Health Plan:

    - The Employer as the Plan Administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Corporation's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,
    - Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

  - Establishment of Procedures for Determining Qualified Status of Orders

    The Employer as the Plan Administrator shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

    - Shall be in writing;
    - Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under the Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,
    - Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

  - Actions Taken by Fiduciaries

    If a Plan fiduciary for this Plan of Benefits acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Employer's Group Health Plan's obligation to the Covered Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

- Treatment of Alternate Recipients
  - Under ERISA

    A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under the Employer's Group Health Plan for purpose of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

  - Direct Provision of Benefits Provided to Alternate Recipients

    Any payment for Covered Expenses made by the Employer's Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

  - Plan Enrollment and Payroll Deductions

    If an Employee remains covered under the Employer's Group Health Plan but fails to enroll an Alternate Recipient under the Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional Premium from the Employee's paycheck.

  - Termination of Coverage

    Except for any coverage continuation rights otherwise available under the Employer's Group Health Plan, the coverage for the Alternate Recipient shall end on the earliest of:

    - The date the Employee's coverage ends;
    - The date the Qualified Medical Child Support Order is no longer in effect;
    - The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,
    - The date the Employer eliminates family health coverage for all of its Employees.

COORDINATION OF BENEFITS

APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Covered Member for the same Covered Expenses. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply.

ORDER OF DETERMINATION RULES FOR EMPLOYEE COVERED MEMBERS

When an Employee Covered Member's claim is submitted under the Employer's Group Health Plan and another Plan, the Employer's Group Health Plan is a Secondary Plan unless:

- The other Plan has rules coordinating its benefits with those of the Employer's Group Health Plan; or,
- Both the other Plan's rules and the Employer's Group Health Plan's rules require that benefits be determined under the Employer's Group Health Plan before those of the other Plan; or,
- There is a statutory requirement establishing that the Employer's Group Health Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA.

ADDITIONAL ORDER OF DETERMINATION RULES

The Employer's Group Health Plan coordinates Benefits for non-Employee Covered Members using the first of the following rules that apply:

<u>Dependents</u>

The Plan that covers an individual as an Employee or retiree is the Primary Plan.

<u>Dependent Child – Parents not Separated or Divorced</u>

When the Employer's Group Health Plan and another Plan cover the same Child as a Dependent then benefits are determined in the following order:

- The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.
- If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.
- If the other Plan does not have the rule described in the first bullet above, but instead has a rule based upon the gender of the parent; and if, as a result, the other Plan and the Plan of Benefits do not agree on the order of benefits, the gender rule in the other Plan will apply.

The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

Dependent Child – Separated or Divorced Parents

If two (2) or more Plans cover a person as a Dependent Child of divorced, separated, or unmarried parents, benefits for the Child are determined in the following order:

- First, the Plan of the parent with custody of the Child;
- Second, the Plan of the parent's spouse with the custody of the Child;
- Third, the Plan of the parent not having custody of the Child;
- Fourth, the Plan of the parent's spouse not having custody of the Child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses (or health insurance coverage) 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, that Plan is the Primary Plan. If the parent with responsibility for health care expenses has no health insurance coverage for the Dependent Child, but that parent's spouse does have coverage, the spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or Plan year during which any Benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined above for any Dependent Child whose parents are not separated or divorced.

Active and Inactive Employees

The Plan that covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

Medicare

The Employer's Group Health Plan is a Secondary Plan with respect to Medicare benefits except where federal law mandates that the Employer's Group Health Plan be the Primary Plan. Any claims where Medicare is primary must be filed by the Covered Member after Medicare payment is made.

Longer and Shorter Length of Coverage

If none of the above rules determines the order of benefits, the Plan that has covered the Covered Member longer is the Primary Plan.

EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

The Employer's Group Health Plan as Primary Plan

When the Employer's Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

The Employer's Group Health Plan as Secondary Plan

When the Employer's Group Health Plan is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

- The Covered Expenses in the absence of this coordination of benefits provision; plus
- The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the Benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Employer's Group Health Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Employer's Group Health Plan. The benefits payable by the Primary Plan and the Benefits payable by the Corporation will not total more than the Allowable Charge.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be a Covered Expense.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not a Covered Expense unless the Covered Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Covered Member does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Employer's Group Health Plan (including through the Corporation) is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions and the Covered Member and the Employer must provide any such information as reasonably requested.

PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan of Benefits. In such a case, the Employer's Group Health Plan may pay that amount to the organization that made such payment. That amount will then be treated as though it had been paid under this Plan of Benefits. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Employer's Group Health Plan is more than the Employer's Group Health Plan should have paid under this Coordination of Benefits section, the Employer's Group Health Plan may recover the excess or overpayment from the Covered Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Covered Member with respect to such overpayments.

SUBROGATION/RIGHT OF REIMBURSEMENT PROVISION

BENEFITS SUBJECT TO THIS PROVISION

This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan are being provided by a self-funded plan.

STATEMENT OF PURPOSE

Subrogation and Reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Employer's Group Health Plan may have a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

DEFINITIONS

Another Party
Another Party shall mean any individual or entity, other than this Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Member's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Member's own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a Workers' Compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

Covered Member
As it relates to the Subrogation and Reimbursement Provision, a Covered Member shall mean any person, Dependent or representatives, other than the Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Covered Member shall include but is not limited to any beneficiary, Dependent, spouse or person who has or will receive Benefits under the Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Covered Member, and heirs of the estate.

Recovery
Recovery shall mean any and all monies identified, paid or payable to the Covered Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Covered Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Plan's lien. The amount owed from the Recovery as Reimbursement of the Plan's lien is an asset of the Plan.

Reimbursement
Reimbursement shall mean repayment to the Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

Subrogation
Subrogation shall mean the Plan's right to pursue the Covered Member's claims for medical or other charges paid by the Plan against Another Party.

When this Provision Applies:
This provision applies when a Covered Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Covered Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Covered Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Covered Member agrees, as a condition of receiving Benefits from the Plan, to transfer to the Plan all rights to recover damages in full for such Benefits.

Duties of the Covered Member:
The Covered Member will execute and deliver all required instruments and papers provided by the Plan Administrator/Employer's Group Health Plan, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Plan Administrator/Employer's Group Health Plan may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to Subrogation and Reimbursement. In addition, the Covered Member will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A Covered Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's lien to the Plan under the terms of this provision. A Covered Member who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Plan's portion of the Recovery in constructive trust for the Plan, because the Covered Member is not the rightful owner of the Plan's portion of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed. The portion of the Recovery owed by the Covered Member for the Plan's lien is an asset of the Plan.

As a condition of receiving Benefits, the Covered Member must:

- Immediately notify the Plan Administrator/Employer's Group Health Plan of an injury or illness for which Another Party may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

- Execute and deliver an Accident Questionnaire within one hundred eighty (180) days of the Accident Questionnaire being mailed to the Covered Member;

- Deliver to the Plan Administrator/Employer's Group Health Plan a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

- Deliver to the Plan Administrator/Employer's Group Health Plan a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;

- Authorize the Plan to sue, compromise and settle in the Covered Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Member's rights to Recovery when this provision applies;

- Include the Benefits paid by the Plan as a part of the damages sought against Another Party. Immediately reimburse the Plan, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

- Immediately notify the Plan Administrator/Employer's Group Health Plan in writing of any proposed settlement and obtain the Plan Administrator/Employer's Group Health Plan's written consent before signing any release or agreeing to any settlement; and,

- Cooperate fully with the Plan Administrator/Employer's Group Health Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan Administrator/Employer's Group Health Plan.

First Priority Right of Subrogation and/or Reimbursement:
Any amounts recovered will be subject to Subrogation or Reimbursement. The Plan will be subrogated to all rights the Covered Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Plan's payments. In addition, the Plan shall have a first priority equitable lien against any Recovery to the extent of benefits paid and to be payable in the future. The Plan's first priority equitable lien supersedes any right that the Covered Member may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Member procures or may be entitled to procure regardless of whether the Covered Member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally**,** the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Plan, the Covered Member agrees that acceptance of Benefits is constructive notice of this provision.

When a Covered Member Retains an Attorney:
An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's equitable lien to the Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Covered Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Plan's portion of the Recovery immediately over to the Plan. A Covered Member's attorney who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Covered Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Plan's lien. The portion of the Recovery owed for the Plan's lien is an asset of the Plan.

If the Covered Member retains an attorney, the Covered Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of Recovery. The Plan will not pay the Covered Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Member's attorneys' fees and costs, without the expressed written consent of the Plan Administrator.

When the Covered Member is a Minor or is Deceased or Incapacitated:
This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Covered Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Covered Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Plan Administrator/Employer's Group Health Plan.

When a Covered Member Does Not Comply:
When a Covered Member does not comply with the provisions of this section, the Plan Administrator/Employer's Group Health Plan shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Covered Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan by the amount due as satisfaction for the Reimbursement to the Plan. The Plan Administrator/Employer's Group Health Plan may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Covered Member under any other group benefits plan maintained by the employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Plan must bring an action against a Covered Member to enforce the provisions of this section, then the Covered Member agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Prior Recoveries:
In certain circumstances, a Covered Member may receive a Recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Covered Member's injuries or illness, the Covered Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Plan. In these situations, the Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Covered Member is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses. To the extent a Covered Member's Recovery exceeds the amount of the Plan's lien, the Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Covered Member will be solely responsible for payment of medical bills related to the injuries or illness. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Plan Administrator/Employer's Group Health Plan has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under the Plan for injuries or illness which the Covered Member has already received a Recovery may be considered fraud, and the Covered Member will be subject to any sanctions determined by the Plan Administrator/Employer's Group Health Plan, in their sole discretion, to be appropriate, including denial of present or future Benefits under the Plan.

WORKERS' COMPENSATION PROVISION

This policy does not provide Benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Covered Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Covered Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Covered Member but the Covered Member or the Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or, the Covered Member sought treatment for the injury or illness from a provider not authorized by the Covered Member's Employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Plan Administrator/Employer's Group Health Plan may, in its sole discretion, agree to extend Benefits to a Covered Member for the injury or illness. In this instance, the Covered Member agrees, as a condition of receiving Benefits, to reimburse the Plan in full from any workers' compensation recovery as described herein. The Covered Member further agrees as a condition of receiving benefits, to execute and deliver all required instruments and papers provided by the Plan Administrator/Employer's Group Health Plan, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's right of recovery, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Plan Administrator/Employer's Group Health Plan may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to reimbursement from any workers' compensation recovery the Covered Member may receive.

As a condition of receiving Benefits, the Covered Member must:

- Immediately notify the Plan Administrator/Employer's Group Health Plan of an injury or illness for which his/her Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
- Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Covered Member;
- Deliver to the Plan Administrator/Employer's Group Health Plan a copy of the police report, incident or accident report, or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;
- Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Covered Member may be entitled;
- Include the Benefits paid by the Plan as a part of the damages sought against his/her Employer and/or Employer's Workers' Compensation carrier. Immediately reimburse the Plan, out of any recovery made from the Employer and/or Employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

- Immediately notify the Plan Administrator/Employer's Group Health Plan in writing of any proposed settlement and obtain the Plan Administrator/Employer's Group Health Plan's written consent before signing any release or agreeing to any settlement; and,
- Cooperate fully with the Plan Administrator/Employer's Group Health Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan Administrator/Employer's Group Health Plan.

The Plan Administrator/Employer's Group Health Plan has sole discretion to determine whether claims for Benefits submitted to the Plan are related to the injuries or illness to the extent this provision applies. If the Plan Administrator/Employer's Group Health Plan pays Benefits for an injury or illness and the Plan Administrator/Employer's Group Health Plan determines the Covered Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Covered Member shall reimburse the Plan from the recovery for all Benefits paid by the Plan relating to the injury or illness. However, under no circumstances shall the Covered Member's reimbursement to the Plan exceed the amount of such recovery.

If the Covered Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Plan's right of reimbursement from the recovery will be applied even if: liability is denied, disputed, or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Covered Member's employment; the amount of workers' compensation benefits due to medical or health care is not agreed upon or defined by the Covered Member, Employer or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the settlement or compromise.

Failure to reimburse the Plan from the recovery as required under this section will entitle the Plan Administrator/Employer's Group Health Plan to invoke the workers' compensation exclusion and deny payment for all claims relating to the injury or illness.

ERISA RIGHTS

If the Plan of Benefits is covered by ERISA, each Covered Member in the Plan of Benefits is entitled to certain rights and protections under ERISA. ERISA provides that all Covered Members shall be entitled to:

RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Employer's Group Health Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Employer's Group Health Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Employer's Group Health Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Plan Administrator may assess a reasonable charge for the copies.

Receive, upon request, a summary of the Employer's Group Health Plan annual financial report. The Plan Administrator is required by law to furnish each Covered Member with a copy of this summary annual report.

CONTINUATION COVERAGE

Covered Members are entitled to continue health care coverage for themselves and their Dependents if there is a loss of coverage under the Employer's Group Health Plan as a result of a Qualifying Event. The Covered Member or Dependents may have to pay for such continuation coverage. Employee Covered Members should review the documents governing continuation coverage rights.

Covered Members may be entitled to a reduction or elimination of Pre-Existing Condition Waiting Periods if the Covered Member has Creditable Coverage from another Group Health Plan. Covered Members should be provided a Certificate of Creditable Coverage, free of charge, from the Covered Member's prior Group Health Plan or health insurance issuer when:

- The Covered Member loses coverage under such Group Health Plan; or,
- When the Covered Member becomes entitled to elect continuation coverage; or,
- When the Covered Member's continuation coverage ceases.

A Covered Member is entitled to a Certificate of Creditable Coverage if such Covered Member requests it before losing coverage, or if the Covered Member requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, the Covered Member may be subject to a Pre-Existing Condition Waiting Period.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Members, ERISA imposes duties upon the people who are responsible for the operation of an Employee welfare benefit Plan. The people who administer an Employee welfare benefit Plan are called "fiduciaries," and have a duty to do so prudently and in the interest of the Covered Members. The Employer is the fiduciary of the Employer's Group Health Plan.

ENFORCEMENT OF EMPLOYEE RIGHTS

If a Covered Member's claim for a Benefit is denied or ignored, in whole or in part, such Covered Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Member can take to enforce the rights described above. For instance, if a Covered Member requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, such Covered Member may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay such Covered Member up to $110 a day until such Covered Member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Covered Member has a claim for Benefits that is denied or ignored, in whole or in part, such Covered Member may file suit in a state or federal court. In addition, if a Covered Member disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, such Covered Member may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Member is discriminated against for asserting such Covered Member's rights, such Covered Member may seek assistance from the U.S. Department of Labor, or such Covered Member may file suit in a federal court. The court will decide who should pay court costs and legal fees. If a Covered Member is successful the court may order the person the Covered Member has sued to pay these costs and fees. If the Covered Member loses, the court may order such Covered Member to pay these costs and fees, for example, if it finds such Covered Member's claim is frivolous.

No one, including the Employer, the Covered Members' union, or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

ASSISTANCE WITH QUESTIONS

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

GENERAL PROVISIONS

ADMINISTRATIVE SERVICES ONLY

The Corporation provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Employer's Group Health Plan is a self-funded health Plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT

Upon thirty (30) days prior written notice, the Employer may unilaterally amend this Plan of Benefits. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Notice of an amendment will be effective when addressed to the Employer. The Corporation has no responsibility to provide individual notices to each Covered Member when an amendment to the Employer's Group Health Plan has been made.

AUTHORIZED REPRESENTATIVES

A Provider may be considered a Covered Member's Authorized Representative without a specific designation by the Covered Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Covered Member's Authorized Representative with regard to non-Urgent Care Claims only when the Covered Member gives the Corporation or the Provider a specific designation, in a format that is reasonably acceptable to the Employer's Group Health Plan to act as an Authorized Representative. If the Covered Member has designated an Authorized Representative, all information and notifications will be directed to that representative unless the Covered Member gives contrary directions. The Covered Member should contact the Corporation for information regarding Authorized Representatives.

CLERICAL ERRORS

Clerical errors by the Corporation or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

DISCLOSURE OF PHI TO PLAN SPONSOR

The Employer's Group Health Plan will disclose (or will require BlueCross BlueShield to disclose) Covered Member's Protected Health Information (PHI) to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of this section.

- Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.

    - The Plan Sponsor will neither use nor further disclose Covered Member's PHI, except as permitted or required by the Plan Documents, as amended, or required by law.

    - The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Covered Member PHI agrees to the restrictions and conditions of the Plan of Benefits, with respect to Covered Member's PHI.

    - The Plan Sponsor will not use or disclose Covered Member PHI for employment-related actions or decisions or in connection with any other Benefit or Employee benefit Plan of the Plan Sponsor.

    - The Plan Sponsor will report to the Employer's Group Health Plan any use or disclosure of Covered Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

    - The Plan Sponsor will make PHI available to the Covered Member who is the subject of the information in accordance with HIPAA.

    - The Plan Sponsor will make Covered Member PHI available for amendment, and will on notice amend Covered Member PHI, in accordance with HIPAA.

    - The Plan Sponsor will track disclosures it may make of Covered Member PHI so that it can make available the information required for the Employer's Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

    - The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of Covered Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

    - The Plan Sponsor will, if feasible, return or destroy all Covered Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Employer's Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Covered Member who is the subject of the PHI, when the Covered Member's PHI 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 Covered Member PHI, the Plan Sponsor will limit the use or disclosure of any Covered Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

    - The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI (ePHI) that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan.

- The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides electronic PHI (that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan) agrees to implement reasonable and appropriate security measures to protect this information.

- The Plan Sponsor shall report any security incident of which it becomes aware to the Employer's Group Health Plan as provided below.

    i. In determining how and how often Plan Sponsor shall report security incidents to Employer's Group Health Plan, both Plan Sponsor and Employer's Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Employer's Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do <u>not</u> result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:

        - Pings on a Party's firewall,
        - Port scans,
        - Attempts to log on to a system or enter a database with an invalid password or username,
        - Denial-of-service attacks that do not result in a server being taken off-line, and,
        - Malware (e.g., worms, viruses)

    ii. Plan Sponsor shall, however, separately report to Employer's Group Health Plan (i) any successful unauthorized access, use, disclosure, modification, or destruction of the Group Health Plan's electronic PHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's electronic PHI; or (c) results in a breach of availability of Group Health Plan's electronic PHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's electronic PHI.

- Adequate Separation Between the Plan Sponsor and the Employer's Group Health Plan.

    - Certain classes of Employees or other workforce Covered Members under the control of the Plan Sponsor may be given access to Covered Member PHI received from the Employer's Group Health Plan or business associate servicing the Employer's Group Health Plan.

    - These Employees will have access to Covered Member PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Employer's Group Health Plan.

    - These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Covered Member PHI in breach or violation of or noncompliance with the provisions of this section to the Plan of Benefits. Plan Sponsor will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan, and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce Covered Member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Covered Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

    - The Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

Plan Sponsor certifies that the Plan of Benefits contains and that the Plan Sponsor agrees to the provisions outlined above.

GOVERNING LAW

The Employer's Group Health Plan is governed by and subject to ERISA and any other applicable federal law. If ERISA or another federal law does not apply, the Employer's Group Health Plan is governed by and subject to the laws of the State of Louisiana. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Employer's Group Health Plan conflicts with such law, the Employer's Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Covered Member must present their Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Covered Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS

The Corporation and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and health care operations for the administration of the Benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No Covered Member may bring an action at law or in equity to recover on the Employer's Group Health Plan or this Plan of Benefits until such Covered Member has exhausted the appeal process as set forth in the section entitled "Claims Filing and Appeals Procedures". No such action may be brought after the expiration of any applicable period prescribed by law.

NEGLIGENCE OR MALPRACTICE

The Corporation and Employer do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Covered Member by a Provider is rendered or supplied by such Provider and not by the Corporation or the Employer. The Corporation and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under the Employer's Group Health Plan may be given by United States mail, postage paid and addressed:

To the Corporation:

BlueCross BlueShield
Post Office Box 100121
Columbia, South Carolina 29202

To a Covered Member:

To the last known name and address listed for the Employee related to such Covered Member on the Membership Application. Covered Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.

To the Employer:

To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation and Covered Members of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, the Corporation (on behalf of the Employer's Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Employer's Group Health Plan or Employer waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE

Each Covered Member must provide the Employer's Group Health Plan (and its designee, including the Corporation) and Employer with information regarding all other health insurance coverage to which such Covered Member is entitled.

PAYMENT OF CLAIMS

A Covered Member is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Employer's Group Health Plan may pay all Covered Expenses directly to the Employee upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Employee, the Employee is responsible for any Payment to the Provider. Where a Covered Member has received Benefits from a Participating Provider, the Employer's Group Health Plan will pay Covered Expenses directly to such Participating Provider.

PHYSICAL EXAMINATION

The Employer's Group Health Plan has the right to examine, at their own expense, a Covered Member whose injury or sickness is the basis of a claim (whether Pre-Service, Post-Service, Concurrent or Urgent Care). Such physical examination may be made as often as the Employer's Group Health Plan (through its designee, including the Corporation) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

REPLACEMENT COVERAGE

If this Plan of Benefits replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of this Plan of Benefits, provided such persons are enrolled for coverage as stated in the section entitled "Eligibility Requirements".