

**GROUP BENEFIT PLAN**  
FOR THE EMPLOYEES OF  
**GALLIANO MARINE  
SERVICE, LLC**

Administered by



5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802  
[www.bcbsla.com](http://www.bcbsla.com)





**GALLIANO MARINE SERVICE, LLC.  
CHOUEST GROUP HEALTH PLAN  
COMPREHENSIVE MEDICAL BENEFIT PLAN**

**NOTICES**

Your Plan Administrator and Blue Cross and Blue Shield of Louisiana believe this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, 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 Your Plan may not include certain consumer protections of the Affordable Care Act 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 the Affordable Care Act, 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 Your Plan Administrator or to Blue Cross and Blue Shield of Louisiana at the telephone number on the back of Your ID card. ERISA Plan Participants may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. Plan Participants who are not on ERISA plans may contact the U.S. Department of Health and Human Services at [www.healthcare.gov/](http://www.healthcare.gov/).

Plan sponsors of grandfathered benefit plans are required by law to notify the group Underwriting Department of Blue Cross and Blue Shield of Louisiana immediately, if the contribution rate toward the insurance premium for this coverage changes at any point during the Plan Year.

Health care services may be provided to You at a Network health care facility by facility-based physicians who are not in Your health plan’s Network. You may be responsible for payment of all or part of the fees for those Out-of-Network services, in addition to applicable amounts due for Copayments, Coinsurance, Deductibles and non-covered services. Specific information about In-Network and Out-of-Network facility-based Physicians can be found at [www.bcbsla.com](http://www.bcbsla.com) or by calling the customer service telephone number on the back of Your identification (ID) card.

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

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

A handwritten signature in black ink, appearing to read "I. Steven Udvarhelyi".

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

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company



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## **ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE**

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

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

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

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

### **FACTS ABOUT THIS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN**

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

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

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

### **CLAIMS ADMINISTRATOR'S PROVIDER NETWORK**

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

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

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

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

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

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

### **RECEIVING CARE OUTSIDE THE PREFERRED NETWORK**

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

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

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

### **OBTAINING EMERGENCY AND NON-EMERGENCY CARE OUTSIDE LOUISIANA AND AROUND THE WORLD**

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

#### **In the United States:**

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

#### **Outside the United States:**

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

In an Emergency, go directly to the nearest Hospital.

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

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

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

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

## **AUTHORIZATIONS**

Some services and supplies require Authorization from the Claims Administrator before services are obtained. Your Schedule of Benefits lists the services, supplies, and Prescription drugs that require this advance Authorization. See the Care Management Article of this Benefit Plan for additional information regarding Authorization. No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless the Plan Authorizes these services and the services are rendered by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or by a transplant facility in a Blue Cross and Blue Shield of Louisiana Preferred Provider Network, unless otherwise approved by the Plan in writing. To locate an approved transplant facility, Plan Participants should contact the Plan's customer service department at the number listed on their I.D. card.

## **HOW THE PLAN DETERMINE WHAT IS PAID FOR COVERED SERVICES**

### **When a Plan Participant Uses Preferred Providers**

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

### **When a Plan Participant Uses Participating Providers**

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

### **When a Plan Participant Uses Non-Participating Providers**

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

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

The Plan Participant has the right to file an Appeal with the Claims Administrator for consideration of a higher level of Benefits if the Plan Participant received Covered Services from a Non-Participating Provider who was the only Provider available to deliver the Covered Service within a fifty (50) mile radius of the Plan Participant's home. To file an Appeal, the Plan Participant must follow the Appeal procedures set forth in this Benefit Plan.

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

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

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

The Plan Participant receives Covered Services from:	Preferred Network Provider Hospital	Participating Provider Hospital	Non-Participating Provider Hospital
<b>Provider's Bill:</b>	<b>\$12,000</b>	<b>\$12,000</b>	<b>\$12,000</b>
<b>Allowable Charge:</b>	<b>\$2,500</b>	<b>\$3,000</b>	<b>\$2,500</b>
<b>The Plan pays:</b>	<b>\$2,000</b>	<b>\$1,800</b>	<b>\$1,500</b>
	<b>\$2,500 Allowable Charge x 80% Coinsurance = \$2,000</b>	<b>\$3,000 Allowable Charge x 60% Coinsurance = \$1,800</b>	<b>\$2,500 Allowable Charge x 60% Coinsurance = \$1,500</b>
<b>Plan Participant pays:</b>	<b>\$500</b>	<b>\$1,200</b>	<b>\$1,000</b>
	<b>20% Coinsurance x \$2500 Allowable Charge = \$500</b>	<b>40% Coinsurance x \$3,000 Allowable Charge = \$1,200</b>	<b>\$2,500 Allowable Charge x 40% Coinsurance = \$1000</b>
<b>Is Plan Participant billed up to the Provider's billed charge?</b>	<b>NO</b>	<b>NO</b>	<b>YES - \$9,500, for a total of:</b>
<b>Total Plan Participant Pays:</b>	<b>\$500</b>	<b>\$1,200</b>	<b>\$10,500</b>

**WHEN A PLAN PARTICIPANT RECEIVES MENTAL HEALTH BENEFITS,  
SUBSTANCE ABUSE BENEFITS**

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

**ASSIGNMENT OF BENEFITS**

A Plan Participant's rights and Benefits under this Plan are personal to him and may not be assigned in whole or in part by the Plan Participant. The Claims Administrator will recognize assignments of Benefits to Hospitals

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

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

### **PLAN PARTICIPANT INCENTIVES**

Sometimes the Claims Administrator offers coupons, discounts, or other incentives to encourage Plan Participants to participate in various programs such as pharmacy programs, wellness programs, or disease management programs. A Plan Participant may wish to decide whether to participate after discussing such programs with their Physicians. These incentives are not Benefits and do not alter or affect Plan Participant Benefits.

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

### **CUSTOMER SERVICE E-MAIL ADDRESS**

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

## ARTICLE II.

## DEFINITIONS

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

Active Employee (Active Employment) – See definition for “Actively at Work.”

Actively at Work – An Employee will be considered actively at work if the Employee is performing the regular duties of employment on that day either at the Group’s place of business or at some location to which the Employee is required to travel for the Group’s business. An Employee is considered to be actively at work on each day of a regular paid vacation and on each regular non-work day on which the Employee is able to perform the essential functions of his job, if the Employee was actively at work on the last preceding regular work day. Exceptions to ‘Actively at Work’ include:

- A. Employees who are not actively at work because they are out on Family Medical Leave Act leave or some other type of employer-sanctioned leave.
- B. Employees who although actively employed, are not actively at work due to their work schedule (i.e. vessel employees).
- C. Employees who although actively employed are not actively at work due to a work-related injury.

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

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

- A. Medical Necessity, appropriateness, health care setting, level of care, effectiveness or treatment is determined to be experimental or Investigational;
- B. the Plan Participant's eligibility to participate in the Benefit Plan;
- C. any prospective or retrospective review determination; or
- D. a Rescission of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

Copayment (Copay) – The specific dollar amount a Plan Participant must pay when specified Covered Services are rendered. Copayment amounts are listed in the Schedule of Benefits, and may be collected directly from the Plan Participant by a Network Provider. The Plan Participant is responsible for paying the lesser of:

- The applicable Copayment, or
- The Allowable Charge.

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

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

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

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

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

Deductible Amount –

- Individual Deductible Amount – The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Plan Participant must pay within a Benefit Period before the Benefit Plan starts paying Benefits. Once the Family Deductible Amount is satisfied, this Plan starts paying Benefits for all Plan Participants of the family, regardless of whether each has met the Individual Deductible Amount. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits. Network and Non-Network categories may each carry a separate Individual Deductible Amount as shown in the Schedule of Benefits.
- Family Deductible Amount - For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits, is required to each satisfy the Individual Deductible Amount the maximum deductible amount that a family must pay before this Plan starts paying Benefits. Once a family has met its Family Deductible Amount, this Plan starts paying Benefits for all Plan Participants of the family, regardless of whether each individual Plan Participant has met the Individual Deductible. No Plan Participant may contribute more than the Individual Deductible Amount to satisfy the aggregate deductible amount required of a family.

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

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

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

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

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

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

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

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

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

Emergency – See “Emergency Medical Condition.”

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

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

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

Employee - A person who is a full time employee or Full-Time Equivalent, as designated by the Employer.

Employer – Galliano Marine Services, LLC

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

Expedited Appeal – A request for immediate review of an Adverse Determination involving an Admission, availability of care, continued Hospital stay, or health care service for which a Plan Participant has received Emergency services, but has not been discharged from a facility.

Full-Time Equivalent (FTE) – An Employee who: (1) is employed on average 30 or more hours per week; or (2) is working less than 30 hours per week on average, but is in the stability period defined under Internal Revenue Code §54.4980H-2(c) and regulations issued thereunder. A temporary Employee does not meet the eligibility requirements under this Benefit Plan unless such temporary Employee is determined by the Employer to be an FTE.

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

Group – Galliano Marine Services, LLC or other legal entity of Chouest Group Health Plan, who is the Plan Administrator and Sponsor of this Plan and for whom Blue Cross and Blue Shield of Louisiana provides claims administration services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by La. R.S. 22:1043 (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under

seventeen (17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Health Benefits of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic Mental Health Benefits, to be determined by the Plan. The definition of (Mental Disorder) Mental Health shall be the basis for determining benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan – Chouest Group Health Plan’s medical Benefits plan for certain Employees of Galliano Marine Services, LLC and is described in this document.

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

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

Plan Sponsor – Galliano Marine Services, LLC, who provides these Benefits on behalf of its eligible Employees, Retirees and their eligible Dependents.

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

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

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

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

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

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

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

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

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

- A. Preferred Provider (Preferred Care Provider) – A Provider who has entered into a contract with the Claims Administrator to participate in its Preferred Care PPO Network, as shown in the Schedule of Benefits. This provider is also referred to as a Network Provider.
- B. Participating Provider – A Provider that has a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan for other than a Preferred Care PPO Provider Network.
- C. Non-Participating Provider – A Provider that does not have a signed contract with the Claims Administrator or another Blue Cross and Blue Shield plan.

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

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

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

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

Retired Employee – A former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to pay to the Plan the contribution amount required from the Retired Employee.

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

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

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

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Plan) within sixty (60) days of losing other certain health coverage or acquiring a new Dependent as a result of marriage, birth, adoption or placement for adoption.

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

- A. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.
- B. Coordination of care is required prior to drug therapy initiation and/or during therapy.
- C. Unique patient compliance and safety monitoring requirements.
- D. Unique requirements for handling, shipping and storage.
- E. Restricted access or limited distribution.

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

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

Surgery –

- A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic exams, incisional and excisional biopsies and other invasive procedures.
- B. The correction of fractures and dislocations.
- C. Pregnancy Care to include vaginal deliveries and caesarean sections.
- D. Usual and related pre-operative and post-operative care.
- E. other procedures as defined and approved by the Plan.

Telemedicine – Health care delivery, diagnosis, consultation, treatment and transfer of medical data by a Physician or Nurse Practitioner in the Preferred Care Network using interactive telecommunication technology. The Network Physician or Nurse Practitioner at one location is able to interact with the Plan Participant at a separate location, via simultaneous two-way video and audio transmission. Telemedicine does not include telephone conversations or electronic mail messages between a Provider and a Plan Participant.

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

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

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

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

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

Waiting Period – See Eligibility Waiting Period.

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



## ARTICLE III.

## SCHEDULE OF ELIGIBILITY

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

### A. Eligibility

1. Employee. To be eligible to enroll as an Employee, an individual must be:
  - a. an employee who has satisfied any criteria designated by the Plan, has satisfied any Eligibility Waiting Period required by the Plan and who is working the number of hours designated by the Plan in the Application for Group coverage. Coverage is extended to employees and their legal Dependents who reside in the United States under the authorization of a Visa. Dependents who do not enter the United States at the same time as the employee may be added to the plan within sixty (60) days of entry into the United States with an effective date of the first of the month following the date the Dependent enters the United States. Any previous owner of the Plan who has been approved for coverage pursuant to policies and procedures adopted by the Plan is also eligible to enroll.
  - b. a retiree; a former employee who has satisfied criteria designated by the Plan, who reaches age sixty-two (62), and has twenty (20) years of service may continue their health coverage as an active employee until age sixty-five (65).
2. Dependent. To be eligible to enroll as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Claims Administrator that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Benefit Plan.
  - a. SPOUSE: The Employee's legal spouse.
  - b. CHILDREN: A child under age twenty-six (26) who is one of the following:
    - (1) born of the Employee; or
    - (2) legally placed for adoption with the Employee; or
    - (3) legally adopted by the Employee; or
    - (4) a child, residing with the Employee, for whom the Employee or his legal spouse and has been granted legal custody via court order; or
    - (5) a child supported by the Employee pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN). Employees and beneficiaries of this Benefit Plan may obtain, without charge, a description of procedures for QMCSO determinations from the Plan Administrator; or
    - (6) a stepchild of the Employee; or
    - (7) a grandchild residing with the Employee, provided the Employee has been granted legal custody via court order of the grandchild; or
    - (8) the Employee's child, or grandchild in the legal custody of and residing with the Employee, who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining age twenty-six (26). The Employee must furnish the Plan with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's twenty-sixth (26<sup>th</sup>) birthday. The Plan may require subsequent proof once a year after the initial two-year period following the child's twenty-sixth (26<sup>th</sup>) birthday. The otherwise eligible child or grandchild must be enrolled in the Plan at the time the disability arises in order to be eligible for this extension.

THE GROUP HAS FULL DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY OF COVERAGE FOR ALL EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS AND MAY REQUEST PROOF OF DEPENDENCY STATUS AT ANY TIME.

**B. Enrollment for Coverage**

1. Every Eligible Person may enroll for coverage under this Benefit Plan and may include any eligible dependents.
2. The Plan Administrator will submit all enrollment information to the Claims Administrator as a prerequisite to coverage under this Benefit Plan.

**C. Available Classes of Coverage**

The classes of coverage defined below are available subject to the selection of class or classes of coverage by the Plan as shown on the Application for Group Coverage. The Plan has the right to change the classes of coverage selected when needed by sending a request to change classes to Claim Administrator's Underwriting Department.

1. Employee Only coverage means coverage for the Employee only.
2. Employee and Family coverage means coverage for the Employee, his legal spouse, and one or more Dependent children.

**D. Effective Date**

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

1. If a person is an Eligible Person on the Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, the Group's Benefit Plan Date will be the Effective Date of coverage.
2. If a person becomes an Eligible Person after the Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) on or before the eligibility date and the enrollment form is received by the Plan within sixty (60) days of the eligibility date, the Effective Date of coverage will be the eligibility date.
3. If an Eligible Person's application for coverage for self or for self and any eligible Dependent(s) is not received by the Plan within sixty (60) days of the eligibility date or Special Enrollment Period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment Period.
4. If a child is born to an Employee holding coverage which includes Dependent children (Employee and Family coverage), and the enrollment form is received by the Plan within sixty (60) days of the date of birth, the Effective Date of coverage will be the date of birth.

**E. Court Ordered Determination**

If a court ordered determination is made to cover an eligible Dependent under an employee's Benefit Plan, the Employee must enroll himself, if not already enrolled, and enroll the eligible Dependent by completing an enrollment form and submitting the enrollment form to the Plan within sixty (60) days after the court ordered determination. If timely enrolled, coverage for the eligible Dependent will be effective on the date of the court ordered determination.

If received more than sixty (60) days after date of court ordered determination child will become effective on the first (1<sup>st</sup>) of the month following date of notice.

## F. Special Enrollment

### 1. Special Enrollment Due to Loss of Certain Other Coverage

Special Enrollment Rights due to loss of certain other coverage are available only to Current Employees and their Dependents. These rights are not available to Retirees.

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

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

- a. The Eligible Person must be eligible for coverage under the terms of this Plan;
- b. The Eligible Person must have declined enrollment under this Plan when offered;
- c. The Eligible Person lost coverage under a plan considered Creditable Coverage for HIPAA Portability purposes;
- d. The Eligible Person coverage described in c. above:
  - (1) was under a COBRA continuation provision and the COBRA continuation period was exhausted due to one of the following:
    - (a) the full COBRA continuation period was exhausted;
    - (b) the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the service area the HMO services, whether or not the choice of the individual in the service area, and there is no other COBRA coverage available;
  - (2) was not under a COBRA continuation provision and lost other health coverage due to:
    - (a) loss of eligibility for coverage. Loss of eligibility for coverage includes but is not limited to the following:
      - (i) loss of eligibility as a result of legal separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the hours of employment;
      - (ii) in the case of coverage offered through a Health Maintenance Organization (HMO) in the individual market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual;
      - (iii) in the case of coverage offered through an HMO in the group market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual, and no other health coverage is available to the individual;
      - (iv) a plan no longer offers any Benefits to the class of similarly situated individuals.
    - (b) termination of employer contributions to the other coverage.

A Special Enrollee under this section must request enrollment for coverage under this Plan within thirty (30) days after other coverage ends (or after the Employer stops contributing toward the other non-COBRA coverage). Coverage will become effective on the date other coverage is lost. Coverage will not

be available if the Plan does not receive the signed enrollment form within thirty (30) days of the loss of other coverage.

2. Special Enrollment of a Dependent Child Due to Loss of Coverage under the Children's Health Insurance Program or a Medicaid Program
  - a. This Plan provides a Special Enrollment Period for an employee or family Dependent(s) covered under Medicaid or State Children's Health Insurance Program ("CHIP"), and loses that coverage because of loss of eligibility. To qualify, the Employee must request coverage in this group health plan no later than sixty (60) days after the date of coverage termination under Medicaid. Request for special enrollment under this section must be received by the Plan within the sixty (60) day period following loss of coverage. When special enrollment under this section is made timely and received by the Plan timely, coverage will become effective on the date of the loss of coverage under Medicaid.
3. Special Enrollment Due to Acquiring a Dependent
  - a. This Benefit Plan shall provide for a special enrollment period during which the Dependent of a participating employee, may be enrolled on the plan. If not already participating, a current employee may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period.
  - b. A person becomes a Dependent of the covered or eligible Employee, through marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, the spouse of the Employee, may be enrolled as a Dependent if he is otherwise eligible for coverage.
  - c. If the Plan Administrator offers multiple health plan options, another option may be chosen by the current Employee, for himself and Dependents when special enrollee status applies.
  - d. The Special Enrollment Period described in this subparagraph is a period of no less than sixty (60) day and shall begin on the later of the date Dependent coverage is made available or the date of the birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied.
  - e. In the case of a birth, adoption, or placement for adoption, a current Employee may enroll himself, his spouse and/or the newborn/adopted child and other eligible dependent children. The enrollment must be requested by signing an enrollment form within thirty (30) days after the birth, adoption, or placement for adoption. Coverage will become effective on the date of birth, adoption, or placement for adoption. An Employee may enroll an unborn child prior to birth; however, coverage will not be effective until the date of birth. Coverage will not be available if the Plan does not receive the signed enrollment form within thirty (30) days of birth, adoption, or placement for adoption.
  - f. In the case of marriage, a current Employee may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested by signing an enrollment form within thirty (30) days of the marriage. Coverage will become effective on the date of marriage. Coverage will not be available if the Plan does not receive the signed enrollment form within thirty (30) days of marriage.
4. In all Special Enrollee circumstances, an Employee must be enrolled in this Plan in order for his Dependent(s) to be enrolled.

#### **ARTICLE IV.**

#### **BENEFITS**

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

#### **A. Benefit Categories**

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

## **B. Deductibles and Coinsurance**

1. Subject to the Deductible Amounts shown in the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in accordance with the Coinsurance percentage shown in the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Plan Participant during a Benefit Period. The following deductibles may apply to Benefits provided by this Plan. Deductibles do not accrue to the Out-of-Pocket Amount.
  - a. Individual Deductible Amount: The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that the Plan Participant must pay within a Benefit Period before the Plan starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in the Schedule of Benefits.
  - b. Family Deductible: For Plan Participants in a class of coverage with more than one (1) Plan Participant, no more than the amount shown in the Schedule of Benefits is required to each satisfy the Individual Deductible Amount. Once the family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all covered members of the family, even if each covered family member has not met the Individual Deductible. No Plan Participant may contribute more than the Individual Deductible Amount to satisfy the maximum amount required of a family. Only Individual Deductible Amounts accrue to the Family Deductible Amount.
2. The Coinsurance percentage is shown on the Schedule of Benefits for a Covered Service. The Plan Participant must first pay any applicable Deductible amount before the Coinsurance percentage. After any applicable Deductible amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, the Plan will provide Benefits in the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges for Covered Services. The actual payment to a Provider or payment to the Plan Participant satisfies the Plan Sponsor's obligation to provide Benefits under this Benefit Plan.
3. The Allowable Charges incurred for Covered Services during the months of October, November and December, which were applied toward the Individual Deductible Amount for that Benefit Period will be applied to the Individual Deductible Amount for the next calendar year. This Deductible carryover feature is available whether or not the Deductible Amount is met or exceeded. This carryover feature applies to the Individual Deductible Amount only. It does not apply to the Family Deductible Amount, or any other type of deductible described in this Benefit Plan.
4. The Claims Administrator will apply the Plan Participant's Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Plan Participant, then when the Plan Participant receives Covered Services from another Provider, that Provider also collects the Plan Participant's Deductible Amount. This generally occurs when the Plan Participant's Claims have not been received and processed by the Claims Administrator. The Claims Administrator's system will only show the Deductible Amount applied for Claims that have been processed. Therefore, the Plan Participant may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Plan Participant overpays his Deductible Amount, he is entitled to receive a refund from the Provider to whom the overpayment was made.
5. Under certain circumstances, if the Plan pays a healthcare Provider amounts that are the Plan Participant's responsibility, such as Deductibles, Copayments or Coinsurance, the Plan may collect

such amounts directly from You.

### **C. Copayment Services**

1. The Office Visit Copayment means the Outpatient services when rendered in the office or clinic of a Preferred Provider who is a Physician, Osteopath or other Network Provider shown in the Schedule of Benefits.
  - a. Office visit charges and consultation;
  - b. Preventive and Wellness office visit and consultation.
2. Copayment services do not include the following services and/or supplies. The following services and/or supplies are subject to the Individual Deductible Amount and applicable Coinsurance percentage shown in the Schedule of Benefits:
  - a. allergy testing;
  - b. injections, allergy serums and vials of allergy medications
  - c. Physical Therapy, Occupational Therapy, and Speech Therapy;
  - d. Chiropractors and Psychiatrists;
  - e. Medical and Surgical supplies;
  - f. surgical procedures;
  - g. radiation treatments obtained in Physician's office;
  - h. Mental Health Benefits; and/or
  - i. Substance Abuse.

### **D. Out-of-Pocket Amount**

1. After the Plan Participant has met the applicable Out-of-Pocket Amount, as shown in the Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Allowable Charges for Covered Services for all covered family members for the remainder of the Benefit Period.
2. The following accrue to the Out-of-Pocket Amount of this Benefit Plan:
  - a. Coinsurance, except benefits payable at 50% Coinsurance
3. The following do not accrue to the Out-of-Pocket Amount of this Benefit Plan:
  - a. Deductible Amount;
  - b. Copayment Amounts;
  - c. any charges in excess of the Allowable Charge;
  - d. any penalties the Plan Participant or Provider must pay;
  - e. charges for non-covered services; and
  - f. any benefits payable at 50% of the Plan Participant's Coinsurance amount which is based on the Allowable Charge.

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

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

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

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Plan Participant requiring an intensive level of care.
3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us. A maximum number of days per Benefit Period may apply if shown in the Schedule of Benefits.
4. In a Residential Treatment Center for Plan Participants with Mental Health or , substance abuse Benefits.

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

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

**C. Pre-Admission Testing Benefits**

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

**ARTICLE VI. MEDICAL AND SURGICAL BENEFITS**

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

**A. Surgical Services**

1. Surgery

- a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by the Plan and is that period of time which is appropriate as routine care for the particular surgical procedure.
  - b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.
2. Multiple Surgical Procedures - When Medically Necessary multiple procedures (concurrent, successive, or other multiple surgical procedures) are performed at the same surgical setting, Benefits will be paid as follows:
- a. Primary Procedure
    - (1) The primary or major procedure will be the procedure with the greatest value based on the Allowable Charge.
    - (2) Benefits for the primary procedure will be based on the Allowable Charge.
  - b. Secondary Procedure(s)

The secondary procedure(s) is a procedure(s) performed in addition to the primary procedure, which adds significant time, risk, or complexity to the Surgery. The Allowable Charge for the secondary procedure will be based on a percentage of the Allowable Charge that would be applied had the secondary procedure been the primary procedure.
  - c. Incidental Procedure
    - (1) An incidental procedure is one carried out at the same time as a more complex primary procedure and which requires little additional Physician resources and/or is clinically integral to the performance of the primary procedure.
    - (2) The Allowable Charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.
  - d. Unbundled Procedure(s)
    - (1) Unbundling occurs when two (2) or more procedure codes are used to describe Surgery performed when a single, more comprehensive procedure code exists that accurately describes the entire Surgery performed. The unbundled procedures will be rebundled for assignment of the proper comprehensive procedure code as determined by the Claims Administrator.
    - (2) The Allowable Charge includes the rebundled procedure. The Plan will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as determined by the Claims Administrator.
  - e. Mutually Exclusive Procedure(s)
    - (1) Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made.



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

### 3. Assistant Surgeon

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

### 4. Anesthesia

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

### 5. Second Surgical Opinion

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

## **B. Inpatient Medical Services**

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

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

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

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

#### D. Expanded Medical and Surgical Benefits

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

### **ARTICLE VII. PRESCRIPTION DRUG BENEFITS**

BLUE CROSS AND BLUE SHIELD OF LOUISIANA DOES NOT PROVIDE CLAIMS PAYMENT SERVICES FOR PRESCRIPTION DRUGS EXCEPT FOR THOSE PRESCRIPTION DRUGS ADMINISTERED DURING AN INPATIENT OR OUTPATIENT STAY OR THOSE REQUIRING PARENTERAL ADMINISTRATION IN A PHYSICIAN'S OFFICE. PLEASE SEE SCHEDULE OF BENEFITS FOR MORE INFORMATION.

### **ARTICLE VIII. PREVENTIVE OR WELLNESS CARE**

Preventive or Wellness Care services are available to a Plan Participant, as described below.

1. Network Benefits – Benefits will be paid at one hundred percent (100%) of the Allowable Charge after a twenty-five dollar (\$25.00) Copayment per date of service.
2. Non-Network Benefits – Benefits will be subject to a Copayment, Deductible amount and the Coinsurance percentage as shown in the Schedule of Benefits.

#### **A. Well Woman Examinations**

1. Two (2) routine annual visits per Benefit Period to an obstetrician/gynecologist, provided that the second visit shall be permitted based upon Medical Necessity only. Follow-up treatments may be made within sixty (60) days following either visit if related to a condition diagnosed or treated during the gynecological exam. Only the first routine annual visit shall be considered Preventive or Wellness Care. The Deductible Amount, Copayment or Coinsurance percentage, if shown in the Schedule of Benefits, applies to all but the first visit.
2. One (1) routine Pap smear per Benefit Period.
3. One (1) mammography examination every calendar year. Additional mammography examinations recommended by the Plan Participant's Physician may be subject to the Deductible Amount and Coinsurance percentage shown in the Schedule of Benefits. .

#### **B. Physical Examinations**

1. Routine Wellness Physical Exam - One (1) routine wellness physical examination per Benefit Period. Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive and Wellness Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels. High Tech Imaging services such as an MRI, MRA, CT scan, PET scan, nuclear cardiology, colonoscopy, flexible sigmoidoscopy and endoscopy are not covered under this Preventive or Wellness Care Benefit. These High Tech Imaging services may be covered under standard Benefits when the tests are Medically Necessary.
2. Well Baby Care – Routine examinations will be covered for infants under the age of 24 months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

#### **C. Immunizations**

1. All state mandated immunizations including the complete basic immunization series as defined by the state health officer and required for school entry for children up to age six (6).

2. Immunizations recommended by the Plan Participant's Physician.
3. Immunizations are subject to Deductible and Coinsurance.

**D. Other Wellness Services**

1. One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for Plan Participants fifty (50) years of age or older, and as recommended by a Physician if the Plan Participant is over forty (40) years of age. A second visit shall be permitted for follow-up treatment within sixty (60) days after the visit if related to a condition diagnosed or treated during the visits.
2. Hemocult (colon) test, limited to one (1) per Benefit Period.

<b>WHAT A PLAN PARTICIPANT PAYS FOR PREVENTIVE OR WELLNESS CARE BENEFITS</b>		
<b>WELLNESS BENEFIT</b>	<b>PREFERRED CARE NETWORK</b>	<b>ALL OTHER PROVIDERS</b>
<b>Well Woman Exams</b>		
OB/GYN office visits	\$25 copayment	Deductible & Coinsurance
Routine Pap Smear	\$25 copayment	Deductible & Coinsurance
Mammogram	\$25 copayment	Deductible & Coinsurance
<b>Physical Exams</b>		
Routine Physical Exam (including related diagnostic tests)	\$25 copayment	Deductible & Coinsurance
Well Baby Care	\$25 copayment	Deductible & Coinsurance
<b>Other Wellness Services</b>		
PSA Test	\$25 copayment	Deductible & Coinsurance
Hemocult (colon) test	\$25 copayment	Deductible & Coinsurance

**ARTICLE IX. MENTAL HEALTH BENEFITS**

- A. Treatment of Mental Disorders is covered. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treatment of Mental Disorders do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.
- B. Inpatient treatment for Mental Disorders must be authorized as provided in the Care Management Article of this Benefit Plan.
- C. Plan Participants who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis when the Claims Administrator Authorizes it for treatment of Autism Spectrum Disorders. Applied Behavior Analysis must be rendered by an appropriately licensed behavior analyst or certified assistant behavior analyst. NOTE: Three (3) hours or more of therapy per day is considered intensive outpatient therapy and requires prior authorization.

**ARTICLE X. SUBSTANCE ABUSE BENEFITS**

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

- B. Inpatient treatment for alcohol and/or drug abuse must be Authorized as provided in the Care Management Article of this Benefit Plan.

NOTE: Three (3) hours or more of therapy per day is considered intensive Outpatient therapy and requires prior Authorization.

#### **ARTICLE XI. ORAL SURGERY BENEFITS**

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

- A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- B. Extraction of impacted teeth (limited to boney impacted wisdom teeth only).
- C. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.) .
- D. Excision of exostoses or tori of the jaws and hard palate.
- E. Incision and drainage of abscess and treatment of cellulitis.
- F. Incision of accessory sinuses, salivary glands, and salivary ducts.
- G. Anesthesia for the above services or procedures when rendered by an oral surgeon.
- H. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Plan Participant's mental or physical condition requires dental treatment to be rendered in a Hospital setting.
- J. Benefits are available for dental services not otherwise covered by this Plan, when specifically required for dental problems caused by any medical condition. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Plan Participant is eligible for these benefits, please call the Claims Administrator's Customer Service Unit at the phone number on the Plan Participant's ID card, and ask to speak to a Case Manager.

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

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

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

#### **A. Acquisition Expenses**

If an organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor's medical expenses are covered as acquisition costs for the recipient under this Plan. If any organ, tissue or bone marrow is sold rather than donated to a Plan Participant, the purchase price of such organ, tissue or bone marrow is not covered.

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

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

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

**C. Solid Human Organ Transplants of the:**

1. liver;
2. heart;
3. lung;
4. kidney;
5. pancreas;
6. small bowel; and
7. other solid organ transplant procedures which the Claims Administrator determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.

**D. Tissue Transplant Procedures (Autologous and Allogeneic), as specified below:**

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

The following tissue transplants are covered:

1. blood transfusions;
2. autologous parathyroid transplants;
3. corneal transplants;
4. bone and cartilage grafting;
5. skin grafting;
6. autologous islet cell transplants; and

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

#### **E. Bone Marrow Transplants**

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

### **ARTICLE XIII. PREGNANCY CARE AND NEWBORN CARE BENEFITS**

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

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

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

#### **A. Pregnancy Care**

1. Medical and Surgical Services.
  - a. Initial office visit and visits during the term of the pregnancy.
  - b. Diagnostic Services.
  - c. Delivery, including necessary pre-natal and post-natal care.
  - d. Medically Necessary abortions required to save the life of the mother.
2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. The Hospital (nursery) charge for well-baby care is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.
3. Elective deliveries prior to the thirty-ninth (39th) week of gestation are not covered unless shown to be Medically Necessary. Facility and other charges associated with an elective early delivery that is not Medically Necessary are also considered to be non-covered.

#### **B. Care for a Newborn when Covered at Birth as a Dependent**

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

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

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

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

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

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

## **ARTICLE XIV. REHABILITATIVE CARE BENEFITS**

Rehabilitative Care Benefits will be available for services provided on an Inpatient or Outpatient basis. I

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

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

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

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

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

### **A. Occupational Therapy**

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

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

## **B. Physical Therapy**

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.
2. Physical Therapy is not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.
3. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.
4. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:
  - a. To children with a diagnosed developmental disability pursuant to the Plan Participant's plan of care.
  - b. As part of a home health care agency pursuant to the Plan Participant's plan of care.
  - c. To a patient in a nursing home pursuant to the Plan Participant's plan of care.
  - d. To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the health care Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the health care Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

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

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

## **D. Chiropractic Services**

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.
2. Chiropractic Services are not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent



regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

3. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.
4. Chiropractic services for dependents age five (5) and under are subject to review for medical necessity.

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

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

### **A. Accidental Injury Benefits**

1. If a Plan Participant incurs medical expenses for treatment or services as a direct result of a traumatic bodily injury sustained solely by accidental means, the Plan agrees to pay one hundred percent (100%) of the Allowable Charge for such medical expenses actually incurred up to the maximum amount shown in the Schedule of Benefits for this Accidental Injury benefit. Once the maximum is exhausted, the Individual Deductible Amount will apply and regular Benefits will be provided to the Plan Participant.
2. No Benefits shall be provided under this Accidental Injury Benefits section for services or supplies rendered in connection with services or supplies provided under other Benefit sections of this Benefit Plan.

NOTE: EXPENSES INCURRED IN CONNECTION WITH ANY ACCIDENTAL BODILY INJURY OR SICKNESS ARISING OUT OF OR IN THE COURSE OF EMPLOYMENT, WHEN COMPENSABLE UNDER ANY WORKERS' COMPENSATION OR OCCUPATIONAL DISEASE ACT OR LAW, AND RECOVERABLE UNDER AN ENFORCEABLE PLAN OF INSURANCE PROVIDING COVERAGE WITH RESPECT TO THOSE OBLIGATIONS ARE NOT ELIGIBLE EXPENSES UNDER THIS BENEFIT PLAN.

### **B. Ambulance Service Benefits**

1. Benefits are available for Ambulance Services for local transportation for Emergency Medical Conditions or Medically Necessary Inpatient Hospital services only as follows:
  - a. for the Plan Participant, to or from the nearest Hospital that can provide services appropriate to the Plan Participant's condition for an illness or injury requiring Hospital care;
  - b. for the Newly Born Infant, to the nearest Hospital or neonatal special care unit for treatment of illnesses, injuries, congenital birth defects and complications of premature birth which require that level of care;
3. Benefits for Air Ambulance services are available in for Emergency Medical Conditions or when the Member is in a location that cannot be reached by ground ambulance. The Air Ambulance service must be specifically requested by police or medical authorities present at the site with the Member in order for Air Ambulance to be covered.

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

3. In a non-emergency situation, air Ambulance Service is not covered unless the Plan Participant requests and receives Authorization from the Claims Administrator prior to the service being rendered.

4. Transport of ambulatory or non-ambulatory individuals for services that can be scheduled in advance (e.g., dialysis) is not a covered Ambulance Service. Transport by wheelchair van is not a covered Ambulance Service.
5. Ambulance Service Benefits will be provided as follows:
  - a. If a Plan Participant pays a periodic fee to an ambulance Membership organization with which the Claims Administrator does not have a Provider Agreement, Benefits for expenses incurred by the Plan Participant for its Ambulance Services will be based on any obligation the Plan Participant must pay that is not covered by the fee. If there is in effect a Provider Agreement between the Claims Administrator and the ambulance organization, Benefits will be based on the Allowable Charge.
  - c. No Benefits are available if transportation is provided for a Plan Participant's comfort or convenience, or when a Hospital transports Plan Participants between parts of its own campus.

Note: Plan Participants can be balanced billed for Ambulance Services received from Non-Network providers.

### **C. Attention Deficit/Hyperactivity Disorder**

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder is covered when rendered or prescribed by a Physician or Allied Health Professional. Benefits provided are the same as any other illness.

### **D. Bone Mass Measurement**

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

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

Deductible and Coinsurance and/or Copayment amounts may be applicable.

### **E. Breast Reconstructive Surgery Services**

1. A Plan Participant who is receiving Benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy will also receive Benefits for the following Covered Services:
  - a. reconstruction of the breast on which the mastectomy has been performed;
  - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.
2. These Covered Services shall be delivered in a manner determined in consultation with the attending Physician and the Plan Participant and, if applicable, will be subject to any Deductible, Copayment and Coinsurance.

### **F. Cleft Lip and Cleft Palate Services**

The following services for the treatment and correction of cleft lip and cleft palate are covered:

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

Coverage is also provided for secondary conditions and treatments attributable to the primary medical condition.

#### **G. Colorectal Cancer Screening Benefits**

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

#### **H. Disposable Medical Equipment and Supplies**

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

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

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

##### **1. Durable Medical Equipment**

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

- (1) It must withstand repeated use;
- (2) It is primarily and customarily used to serve a medical purpose;
- (3) It is generally not useful to a person in the absence of illness or injury; and
- (4) It is appropriate for use in the patient's home.

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

- (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable

Charge (but not to exceed the purchase Allowable Charge). NOTE: Humidifier rental for CPAP machine is covered under this Benefit Plan.

- (2) At Plan's option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.
- (3) Benefits based on the Allowable Charge for standard equipment will be provided toward any deluxe equipment when a Plan Participant selects deluxe equipment solely for his comfort or convenience.
- (4) Benefits for deluxe equipment based on the Allowable Charge for deluxe equipment will only be provided when documented to be Medically Necessary.
- (5) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.
- (6) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost or damaged due to neglect or misuse or for replacement of equipment within five (5) years of purchase or rental will not be covered.

c. Limitations in connection with Durable Medical Equipment.

- (1) There is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.
- (2) There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.
- (3) There is no coverage for repair or replacement of equipment lost or damaged due to neglect or misuse.
- (4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by the plan.

2. Orthotic Devices

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

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.
- b. Repair or replacement of the Orthotic Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. The Plan will determine this time period.
- c. Benefits based on the Allowable Charge for standard devices will be provided toward any deluxe device when a Plan Participant selects a deluxe device solely for his comfort or convenience.
- d. Benefits for deluxe devices based on the Allowable Charge for deluxe devices will only be provided when documented to be Medically Necessary.
- e. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

Benefits will be available for the purchase of Prosthetic Appliances and Devices (other than limb prosthetics and services) that is Authorized by the Claims Administrator and are covered subject to the following:

- a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.
  - b. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the appliance. The Plan will determine this time period.
  - c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Plan Participant selects a deluxe appliance solely for his comfort or convenience.
  - d. Benefits for deluxe appliances based on the Allowable Charge for deluxe appliances will only be provided when documented to be Medically Necessary.
4. Prosthetic Appliances and Devices and Prosthetic Services of the Limbs

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

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

#### **J. Hearing Aid Benefits**

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

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

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

#### **K. Home Health Care Benefits**

Home Health Care services provided to a Plan Participant in lieu of an Inpatient Hospital Admission are covered.

#### **L. Hospice Benefits**

Hospice care is covered and is subject to limitations as shown in the Schedule of Benefits.

## **M. Private Duty Nursing Services**

1. Coverage is available to a Plan Participant for Private Duty Nursing Services as shown in the Schedule of Benefits when performed on an Outpatient basis and when the nurse is not related to the Plan Participant by blood, marriage or adoption. (Authorization is required prior to services being performed.)
2. Private Duty Nursing Services are covered at the Deductible and Coinsurance percentage shown in the Schedule of Benefits.
3. Inpatient Private Duty Nursing Services are not covered.

## **N. Sleep Studies**

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

## **O. X-rays, Lab Tests, Machine Tests, and High-Tech Imaging**

1. The Plan Participant will pay the Physician office visit Copayment only when he visits a Network Provider or other Provider listed in the Copayment Services section. Medically necessary X-rays, lab tests, and machine tests are covered at one hundred percent (100%) of the Allowable Charge, when performed within the office or clinic of a Network Provider that is subject to the Physician office visit Copayment. Lab tests are also covered at one hundred percent (100%) of the Allowable Charge when performed by an independent laboratory that is a Network Provider. X-rays, lab tests, and machine tests taken, performed or processed in an Outpatient Facility or other setting are subject to Deductible and Coinsurance. Lab tests that are taken, performed, or processed by a Non-Network Provider are subject to Deductible and Coinsurance.
2. High-tech imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology, are subject to Deductible and Coinsurance, even if taken in the office or clinic of a Network Provider.

## **ARTICLE XVI.**

## **CARE MANAGEMENT**

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

#### **1. Selection of Provider**

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

- a. If a Plan Participant wants to receive services from a Non-Network Provider and obtain the highest level of Benefits, he must notify the Claims Administrator's Care Management Department before services are rendered. The Claims Administrator will approve the use of a Non-Network Provider only if the Claims Administrator determines that the services cannot be provided by a Network Provider within a fifty (50) mile radius of the Plan Participant's home.

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

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

## **2. Penalties for Failure to Obtain Authorization – of Admissions, Outpatient Services, Other Covered Services**

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

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

### **Admissions**

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

#### **Outpatient Services, Other Covered Services and Supplies**

1. If a Network Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by the amount shown in the Schedule of Benefits. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Network Provider is responsible for all charges not covered.
2. If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown in the Schedule of Benefits. The Plan Participant is responsible for all charges not covered.
3. The Plan Participant remains responsible for any applicable Copayment amount, or any applicable Deductible amount and Coinsurance percentage.
4. if a service or supply was not Medically Necessary, the service or supply is not covered.

## **3. Authorization of Admissions**

### **a. Authorization of Elective Admissions**

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

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

- (2) If Authorization is not requested prior to an Admission, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.
- (3) Additional amounts for which the Plan Participant is responsible because Authorization of an Elective or non-emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

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

- (1) If Authorization is denied by the Claims Administrator for an Admission to any facility, the Admission will not be covered and the Plan Participant must pay all charges incurred for Hospital services during the Admission for which Authorization was denied.
- (2) If Authorization is not requested, the Plan will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.
- (3) Additional amounts for which the Plan Participant is responsible because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not apply toward the Out-of-Pocket Amount.

c. Concurrent Review

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

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



Hospital of the denial. If the Plan Participant elects to remain in the Hospital as an inpatient thereafter, or at the same level of care, the Plan Participant will not be responsible for any charges unless he is notified of his financial responsibility by the Physician or Hospital in advance of incurring additional charges.

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

## **B. Authorization of Outpatient Services, Including Other Covered Services and Supplies**

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

- a. If a request for Authorization is denied by the Claims Administrator, the Outpatient services and supplies are not covered.
- b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, the Plan will have the right to determine if the services and supplies were Medically Necessary. , Benefits will be provided based on the participating status of the Provider.
- c. Additional amounts for which the Plan Participant is responsible because Authorization of Outpatient services and supplies was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

## **C. Appeals**

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

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

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

## **D. Disease Management**

### **1. Qualification**

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

### **2. Disease Management Benefits**

Blue Cross Blue Shield of Louisiana's Disease Management programs are committed to improving the quality of care for its Plan Participants as well as decreasing health care costs in populations with a

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

#### **E. Case Management**

1. The Plan Participant may qualify for Case Management services based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.
2. The role of Case Management is to service the Plan Participant by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.
3. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Case Management services will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant. The provision of Case Management services to one Plan Participant will not entitle any other Plan Participant to Case Management services or be construed as a waiver of the Claims Administrator's right, to administer and enforce this Benefit Plan in accordance with its express terms.
4. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Case Management services.
5. The Plan Participant's Case Management services will be terminated upon any of the following occurrences:
  - a. The Claims Administrator determines that the Plan Participant is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.
  - b. The short and long-term goals established in the Case Management plan have been achieved, or the Plan Participant elects not to participate in the Case Management plan.

#### **F. Alternative Benefits**

1. The Plan Participant may qualify for Alternative Benefits, at the Claims Administrator's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Plan Participant and to the Group.
2. The Claims Administrator's determination that a particular Plan Participant's medical condition renders the Plan Participant a suitable candidate for Alternative Benefits will not obligate the Claims Administrator to make the same or similar determination for any other Plan Participant; nor will the provision of Alternative Benefits to a Plan Participant entitle any other Plan Participant to Alternative Benefits or be construed as a waiver of the Claims Administrator's right, on behalf of the Group, to administer and enforce this Benefit Plan in accordance with its express terms.
3. Unless expressly agreed upon by the Claims Administrator, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Plan Participant is receiving Alternative Benefits.

4. Alternative Benefits provided under the Article are provided in lieu of the Benefits to which the Plan Participant is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.
5. The Plan Participant's Alternative Benefits will be terminated upon any of the following occurrences:
  - a. The Claims Administrator determines, in their sole discretion, that the Plan Participant is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.
  - b. The Plan Participant receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by the Claims Administrator.

## ARTICLE XVII.

## LIMITATIONS AND EXCLUSIONS

- A. Services, supplies and treatment for services that are not covered under this Plan and complications from services, supplies and treatment for services that are not covered under this Plan are excluded.
- B. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown in the Schedule of Benefits, or elsewhere in this policy. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**:
  1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.
  2. Any charges exceeding the Allowable Charge.
  3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.
  4. Services, Surgery, supplies, treatment, or expenses:
    - a. other than those specifically listed as covered by this Plan. Benefits are not payable for services a Plan Participant has no obligation to pay, or for which no charge or a lesser charge would be made if a Plan Participant had no health coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the state of Louisiana or any of its political subdivisions.
    - b. rendered or furnished before the Plan Participant's Effective Date. Charges for Hospital services or supplies rendered or furnished during an Admission in progress on a Plan Participant's Effective Date are not covered until 12:01 AM of the Plan Participant's Effective Date unless otherwise required by law. An Admission in progress on the date the Plan Participant's coverage under this Benefit Plan ends will be covered until the date that coverage ends. The Plan Participant will not receive Benefits for any charges incurred after the date coverage ends;
    - c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;
    - d. to the extent payment has been made or is available under any other contract issued by Blue Cross and Blue Shield of Louisiana or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited benefit policies;

- e. paid or payable under Medicare Parts A or B when a Plan Participant has Medicare, except when Medicare Secondary Payer provisions apply;
  - f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with the Claims Administrator's policies and procedures for such determinations.
  - g. rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of La. R.S. 23:1205(C);
  - h. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or
  - i. rendered by a Provider who is the Plan Participant's spouse, child, stepchild, parent, step-parent or grandparent.
5. Services in the following categories:
- a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
  - b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
  - c. those occurring as a result of taking part in a riot or acts of civil disobedience;
  - d. for treatment of any Plan Participant confined in a prison, jail, or other penal institution; or
  - e. those occurring as a result of a Plan Participant's commission or attempted commission of a crime, criminal act, assault or felony. The Plan Administrator will determine whether a crime occurred, without regard to whether criminal charges are filed or a conviction obtained, and may make the determination under the laws of the jurisdiction where the act occurred or where the Plan is administered. The exclusion does not apply to otherwise coverage benefits for the treatment of an injury that results from an act of domestic violence or for a medical condition (including both physical and mental health conditions), regardless of whether the medical condition was diagnosed before the injury; this exception from the exclusion shall be applied to the extent, and only to the extent, necessary to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.
6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**
- a. rhinoplasty;
  - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
  - c. gynecomastia;
  - d. breast enlargement or breast reduction, **unless** the estimated weight to be removed during breast reduction is greater than five hundred (500) grams excess breast tissue per breast to be reduced; the patient is **not** more than thirty percent (30%) over ideal body weight; and the Plan Participant has one of the following associated symptoms:
    - (1) back, neck, or shoulder pain;
    - (2) parenthesis of hands or arms in ulnar distribution; and/or;
    - (3) permanent shoulder grooving from bras straps;

- e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Benefit Plan;
  - f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;
  - g. diastasis recti;
  - h. biofeedback;
  - i. lifestyle/habit changing clinics and/or programs, except those offered, endorsed, approved, or promoted by the Plan Administrator, which may be part of your health care coverage under this Benefit Plan, or which may be a value-added program subject to minimal additional cost to You, should You voluntarily choose to participate in the program ;
  - j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies.
  - k. industrial testing or self-help programs (including, but not limited to, smoking cessation programs and supplies, and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations;
  - l. recreational therapy, art therapy, dance therapy, massage therapy and/or music therapy;
  - m. primarily to enhance athletic abilities; and/or
  - n. Inpatient pain rehabilitation and pain control programs.
7. Services, Surgery, supplies, treatment, or expenses related to:
- a. routine eye exams, eyeglasses or contact lenses or exams (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered in the Schedule of Benefits;
  - b. eye exercises, visual training, or orthoptics;
  - c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;
  - d. hair pieces, wigs, hair growth, and/or hair implants;
  - e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
  - f. visual therapy.
8. Services, Surgery, supplies, treatment or expenses related to:
- a. any costs of donating an organ or tissue for transplant when a Plan Participant is a donor except as provided in this Benefit Plan;
  - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;
  - c. the transplant of any non-human organ or tissue; or
  - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.
9. Regardless of Medical Necessity services, Surgery, supplies, treatment or expenses related to:

- a. weight reduction programs;
- b. removal of excess fat or skin, or services at a health spa or similar facility; or
- c. obesity or morbid obesity.

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

- 10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings.
- 12. Prescription Drugs, except for those Prescription Drugs administered during an Inpatient or Outpatient stay or those requiring parenteral administration in a Physician's office. The following Prescription Drugs are also excluded:
  - a. Any medication not proven effective in general medical practice;
  - b. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two (2) peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug;
  - c. Fertility drugs;
  - d. Minerals and vitamins, except for vitamins requiring a prescription for dispensation and administered during a hospital stay or in a Physician's office;
  - e. Nutritional or dietary supplements, or herbal supplements and treatments;
  - f. Contraceptive drugs;
  - g. Contraceptive devices of any kind;
  - h. Prescription Drugs related to a non-covered service;
  - i. Medication, drugs or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner; or
  - j. Prescription Drugs for and/or treatment of idiopathic short stature.
- 13. Sales tax or interest.
- 14. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Plan Participant's home or vehicle.
- 15. Telemedicine, including telephone conversations and electronic mail messaging between a Provider and a Plan Participant are not covered services.
- 16. Charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.
- 17. Routine foot care; palliative or cosmetic care or treatment; treatment of flat feet. Except for persons who have been diagnosed with diabetes: cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot.
- 18. Any abortion other than to save the life of the mother.
- 19. Services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian

tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits.

20. Services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.
21. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services.
22. Cosmetic Surgery, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly. Complications resulting from any of these or any other non-covered items are excluded.
23. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under:
  - a. Oral Surgery Benefits
  - b. Cleft Lip and Cleft Palate Services
24. Diagnosis, treatment, or surgery of dentofacial anomalies including but not limited to:
  - a. malocclusion;
  - b. Temporomandibular/Craniomandibular Joint Disorder except as outlined on the Schedule of Benefits.
  - c. hyperplasia or hypoplasia of the mandible and/or maxilla; and
  - d. any orthognathic condition.
25. Medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.
26. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.
27. Education services and supplies including training or re-training for a vocation, diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities.
28. Admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.
29. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.
30. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
31. Hospital charges for a well newborn when services are rendered inside the state of Louisiana. This exclusion is not applicable for services rendered outside the state of Louisiana.
32. Services or supplies for the treatment of Substance Abuse, unless shown as Covered Services in the Schedule of Benefits.
33. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

34. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan.
35. Medical and surgical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).
36. Paternity tests and tests performed for legal purposes.
37. Services, Surgery, supplies, treatment, or expenses of a covered Plan participant related to:
  - a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Plan Participant or as required by law;
  - b. pre-implantation genetic diagnosis;
  - c. preconception carrier screening; and
  - d. prenatal carrier screening except screenings for cystic fibrosis.
38. Voluntary sterilization procedures or reversal of a voluntary sterilization procedure.
39. Rental or purchase of a TENS device and related supplies.
40. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by the Claims Administrator. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by the Claims Administrator.
41. Electric wheelchairs are excluded.
42. Services or supplies for the prophylactic storage of cord blood.
43. Sleep studies unless performed in the home or in a network-accredited sleep laboratory. If a sleep study is performed in a sleep laboratory that is not network, or a sleep study is denied, then neither the sleep study nor any professional claims associated with the sleep study are eligible for coverage
44. Accidental bodily injury or sickness expenses not eligible for benefits under this Benefit Plan are those expenses incurred in connection with any accidental bodily injury or sickness arising out of or in the course of employment, when compensable under any Workers' Compensation or Occupational Disease Act or Law, and recoverable under an enforceable plan of insurance providing coverage with respect to those obligations.
45. Ambulance services for the Temporarily Medically Disabled Mother.
46. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child.
47. Applied Behavior Analysis (ABA) that the Claims Administrator has determined is not Medically Necessary. ABA rendered to Plan Participants age twenty-one (21) and older. ABA rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

## **ARTICLE XVIII.**

## **CONTINUATION OF COVERAGE RIGHTS**

### **A. COBRA Continuation**



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

#### What is COBRA continuation coverage?

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

#### Do I have other alternatives to COBRA continuation coverage?

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

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

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

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

#### What if I choose to get COBRA continuation coverage?

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

#### What are the “qualifying events”?

A “qualifying event” is any of the following events:

- termination of employment of a covered Employee for reasons other than gross misconduct;
- loss of eligibility by a covered Employee due to a reduction in the number of work hours of the Employee;
- death of a covered Employee;
- divorce or legal separation between a covered Employee and his/her spouse;

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

NOTE: Special rules apply for certain retirees and their Dependents who lose coverage because of an employer's Chapter 11 bankruptcy. In this event, certain retirees may elect lifetime COBRA coverage. Eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including but not limited to: the employer ceases to provide any group health plan to any employees or the qualified beneficiaries fail to pay the required premiums or become covered under another employer's group health plan that does not exclude or limit Benefits for a qualified beneficiary's Pre-Existing Conditions. COBRA continuation coverage rights under Chapter 11 bankruptcy proceedings will be determined by the bankruptcy court, and the coverage eligible beneficiaries could receive may not be the same as the ones they had under the retiree plan before the employer filed for Chapter 11 bankruptcy.

#### Do I have to provide notification of any qualifying event?

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

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

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

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

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

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

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

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

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

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

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

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the Employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the Employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or
- thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or
- the date the Employer ceases to maintain any Group health plan for its Employees; or
- the date coverage ceases because of nonpayment of required premiums when due; or
- the date the qualified beneficiary first becomes covered under another group health plan and benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).; or
- the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

### Can I extend my COBRA continuation coverage?

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

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

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

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

The second qualifying event is applicable only if the event would have caused the Dependent to lose coverage under the plan had the first qualifying event not occurred. Qualified beneficiaries must notify the Group within sixty (60) days after a second qualifying event to extend the COBRA continuation coverage.

The eighteen (18) months of continuation coverage may also be extended to a maximum of twenty-nine (29) months if a qualified beneficiary is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) by the Social Security Administration before the first day of COBRA coverage, or is declared disabled during the first sixty (60) days of COBRA coverage.

This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries and elected COBRA continuation coverage for the original eighteen (18) months. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (60) days from:

- the date of the notice from the Social Security Administration of the determination of disability; or
- the date of the qualifying event.

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

Keep Your Plan Informed of Address Changes

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

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

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

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

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

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

1. The employee fails to pay the required premiums timely, or
2. The day after the date on which the employee is required under the law to apply for or return to a position of employment and fails to do so.

Employers subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may choose to provide USERRA continuation coverage rights concurrently with COBRA continuation coverage, as allowed by law. Each employer acts independently in choosing how to apply this provision and is not reflective of any guidelines issued from BCBSLA. In all cases, the employer should be consulted on how this provision applies to their employer group sponsored plan.

Please contact your employer to ask for more details on how USERRA and other continuation coverage rights apply to You.

## **ARTICLE XIX.**

## **COORDINATION OF BENEFITS**

### **A. Applicability**

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

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

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

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

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

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

When This Plan is a Primary Plan, its Benefits are determined before those of the other plan and without considering the other plan’s Benefits. When This Plan is a Secondary Plan, its Benefits are determined after those of the other plan and may be reduced because of the other plan’s Benefits.

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

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

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

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

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

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

1. When there is a basis for a Claim under This Plan and another plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other plan, unless:
  - a. the other plan has rules coordinating its Benefits with those of This Plan; and,
  - b. both those rules and This Plan's rules, in paragraph 2 below, require that This Plan's Benefits be determined before those of the other plan.
2. This Plan determines its order of Benefits using the first of the following rules which applies:
  - a. Non-Dependent/Dependent: The Benefits of the plan which covers the person as an Employee (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is
    - (1) Secondary to the plan covering the person as a Dependent, and
    - (2) Primary to the plan covering the person as other than a Dependent (e.g., a retired Employee), then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.
  - b. Dependent Child/Parents Not Separated or Divorced: Except as stated in paragraph 2(c) below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents:"
    - (1) the Benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but
    - (2) if both parents have the same birthday, the Benefits of the plan which covered one parent longer are determined before those of the plan, which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of Benefits, the rule in the other plan will determine the order of Benefits.
  - c. Dependent Child/Separated or Divorced Parents: If two (2) or more plans cover a person who is a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:

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

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the plan of that parent has actual knowledge of those terms, the Benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan.

This paragraph does not apply when any Benefits are actually paid or provided before the entity has that actual knowledge.

NOTE: Benefits will not be coordinated for Dependent children who have health insurance coverage other than through a parent or step-parent.

- d. **Joint Custody:** If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of Benefit determination rules outlined in Section C.2.b.
- e. **Active/Inactive Employee:** The Benefits of a plan which covers a person as an Employee who is not terminated, laid off, or retired (or as that Employee's Dependent) are determined before those of a plan which covers that person as a terminated, laid off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- f. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of Benefit determination:
  - (1) first, the Benefits of a plan covering the person as an Employee or their Dependent;
  - (2) second, the Benefits under the continuation coverage.If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- g. **Longer/Shorter Length of Coverage:** If none of the above rules determines the order of Benefits, the Benefits of the plan which covered a Plan Participant longer are determined before those of the plan which covered that person for the shorter time.

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

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

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

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

of This Plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses.

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

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

Certain facts are needed to apply these COB rules. This Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give the Claims Administrator any facts it needs to process the Claim.

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

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

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

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

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services. If the excess amount is not received when requested, any Benefits due under this Plan will be reduced by the amount to be recovered until such amount has been satisfied.

### **ARTICLE XX. GENERAL PROVISIONS – GROUP AND PLAN PARTICIPANTS**

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

#### **A. The Benefit Plan**

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



- c. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to Plan Participants for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in the case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition.
2. The Claims Administrator will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with a Plan Participant's care or treatment.
3. The Benefit Plan will not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.
4. The (Plan Administrator) shall administer the Benefit Plan in accordance with its terms and established policies, interpretations, practices and procedures. It is the express intent of this Benefit Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for Benefits, to make determinations on the termination of coverage for its employees and Dependents, to decide disputes which may arise relative to a Subscriber's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.
5. The Claims Administrator shall have the right to enter into any contractual agreements with subcontractors, health care Providers, or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Claims Administrator under this Plan may be performed by the Claims Administrator or any of their subsidiaries, affiliates, subcontractors, or designees.

## **B. Amending and Terminating the Benefit Plan**

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

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

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

## **D. Benefits to Which Plan Participants are Entitled**

1. The liability of the Group is limited to the Benefits specified in this Benefit Plan. If the Benefit Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.
2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Plan Participant's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

## **E. Termination of a Plan Participant's Coverage**

1. The Plan may choose to rescind coverage or terminate a Plan Participant's coverage if a Plan Participant performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained in a required application and enrollment. All representations

made are material to the issuance of this coverage. Any information intentionally omitted from the open enrollment form, as to any proposed or covered Plan Participant, shall constitute an intentional misrepresentation of material fact. A Plan Participant's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Plan Participant's Effective Date, for fraud or intentional misrepresentation of material fact. The Plan will give the Plan Participant sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If you enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, an Employee's coverage terminates as provided below:
  - a. The Employee's coverage and that of all his Dependents automatically terminates at the end of the last day of employment as a full-time Employee or Full-Time Equivalent.
  - b. The coverage of the Employee's spouse will terminate automatically, and without notice at the end of the billing cycle if premiums have been paid through that period.
  - c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent ceases to be an eligible Dependent, if premiums have been paid through that period.
  - d. Upon the death of an Employee, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if Employee contributions have been paid through that period. However, a surviving Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.
3. In the event the Group cancels this Benefit Plan, such cancellation or termination alone will operate to terminate all rights of the Plan Participant to Benefits under the terms of this Benefit Plan as of the effective date of such cancellation or termination. The Group shall have the obligation to notify its Plan Participants, participants, and beneficiaries of such cancellation or termination. The Claims Administrator shall have no such obligation of notification at the Plan Participant level.
4. In the event of the occurrence of the provisions of paragraphs a., b., c. or d. above, if the Plan Participant is an Inpatient in a Hospital on the date coverage ends, medical Benefits in connection with the Admission for that patient will end on the date that coverage ends. No Benefits are available to a Plan Participant for Covered Services rendered after the date of termination of a Plan Participant's coverage.
5. The Claims Administrator reserves the right to automatically change the Plan Participant's class of coverage to reflect when no more Dependents are covered under this Benefit Plan.
6. Employees on Military Leave
  - a. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances.

These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
  - (a) The twenty-four (24) month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during the performance of uniformed service.

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

Galliano Marine Services, LLC  
P.O. Box 310  
Galliano, LA 70354

You may also have continuation rights under USERRA. In general, You must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

A Claim is a written or electronic proof of charges for Covered Services that have been incurred by a Plan Participant during the time period the Plan Participant was covered under this Benefit Plan. The Plan encourages Providers to file Claims in a form acceptable to the Claims Administrator within ninety (90) days from the date services are rendered, but no later than twelve (12) months after the date of service. Benefits will be denied for Claims filed any later than twelve (12) months from the date of service. Benefit Plan provisions in effect at the time the service or treatment is received shall govern the processing of any Claim filed or expense actually incurred as a result of the service or treatment rendered. Corrections or adjustments to Claims must be received within twelve (12) months from the date of service. Exception: in the case the claims are paid nine (9) months after date of service. These claims are allowed three (3) additional months for corrections and adjustments.

#### **G. Applicable Law**

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

#### **H. Time Limit for Legal Action**

No lawsuit may be filed:

- any earlier than the first sixty (60) days after notice of Claim has been given; or
- any later than twelve (12) months after the date services are rendered.

#### **I. Release of Information**

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

#### **J. Assignment**

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

#### **K. Plan Participant/Provider Relationship**

1. The choice of a Provider is solely the Plan Participant's.
2. The Claims Administrator and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or Employees of each other for any purpose whatsoever. The Claims Administrator does not render Covered Services, but only makes payment, on behalf of the Plan, for Covered Services for which the Plan Participant receives. The Plan and The Claims Administrator will not be held liable for any act or omission of any Provider, or for any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Plan Participant while receiving care from any Network Provider or in any Network Provider's facilities. The Plan and The Claims Administrator have no responsibility for a Provider's failure or refusal to render Covered Services to the Plan Participant.
1. The use or non-use of an adjective such as Preferred Network, Participating, and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

#### **L. This Benefit Plan and Medicare**

1. For Employers having twenty (20) or more active employees, federal law and regulations require that each active employee age sixty-five (65) or older, and each active employee's spouse age sixty-five (65) or older, may elect to have coverage under this Plan or under Medicare.
  - a. Where such employee or such spouse elects coverage under this Plan, this Plan will be the primary payor of Benefits with the Medicare program the secondary payor.
  - b. This Plan will not provide Benefits to supplement Medicare payments for Medicare eligible expenses for an active employee age sixty-five (65) or older or for a spouse age sixty-five (65) or older of an active employee where such employee or such spouse elects to have the Medicare program as the primary payor.
2. Under federal law, if an active employee under age sixty-five (65) or an active employee's Dependent under age sixty-five (65) is covered under a group Benefit Plan of an employer with one hundred (100) or more employees and also has coverage under the Medicare program by reason of Social Security disability, the Group Benefit Plan is the primary payor and Medicare is the secondary payor.
3. For persons under age sixty-five (65) who are covered under this Plan and who also have coverage under the Medicare program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor, except that during the first thirty (30) month period that such persons are eligible for Medicare benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.
4. When this Plan is the primary payor, it will provide regular Benefits for Covered Services.

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

lesser of: the Medicare approved amount plus Medicare's limiting charge, if applicable, or the Claims Administrator's Allowable Charge.

#### **M. Notice**

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

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

The Group must report to the appropriate governmental agency any job-related injury or illness of an Employee where so required under the provisions of any legislation of any governmental unit. This Plan, with certain described exceptions, excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of La. R.S. 23:1205(C). In the event Benefits are initially extended by the Plan and a compensation carrier or employer makes any type of settlement with the Employee, or with any person entitled to receive settlement where the Employee dies, or if the Employee's injury or illness is found to be compensable under law, the Employee must reimburse the Plan for Benefits extended or direct the compensation carrier to make such reimbursement. The Group will be entitled to such reimbursement even if the settlement does not mention or excludes payment for health care expenses.

#### **O. Subrogation**

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Group will be subrogated and will succeed to the Plan Participant's right for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier even where such carrier provides Benefits directly to a Plan Participant who is its insured. The acceptance of such Benefits hereunder will constitute acknowledgment of such subrogation rights.
2. The Plan Participant will reimburse the Plan all amounts recovered by suit, settlement, or otherwise from any third party or the Plan Participant's insurer to the extent of the Benefits provided or paid under this Plan. The Plan's right to reimbursement comes first even if the Plan Participant is not paid for all of the Plan Participant's Claim for damages against the other person or organization or even if the payment the Plan Participant receives is for, or is described as for, the Plan Participant's damages other than health care expenses, or if the Plan Participant recovering the money is a minor. All costs that the Plan Participant incurs (including attorney fees) in exercising any right of recovery will be the Plan Participant's responsibility. Amounts that the Plan paid on behalf of the Group for which a third party or insurer is responsible will not be reduced by the amount of the Plan Participant's costs. The Plan Participant shall hold in trust for the account of the Group all amounts recovered, up to the total amount of Benefits paid. The Group appoints the Plan Participant as its representative for such limited purpose only.
3. The Plan Participant will take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of the Plan's rights, and will take no action prejudicing the Plan's rights and interest under this Plan. The Plan and its designees have the right to obtain and review Plan Participant's medical and billing records, if the Plan or its designee determine in their sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits Article of this Benefit Plan.
4. The Plan Participant is required to notify the Plan of any Accidental Injury.

#### **P. Right of Recovery**

Whenever any payment for Covered Services has been made by the Plan, in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan or exceeds the Allowable Charge, or

whenever payment has been made in error by the Plan for non-covered services, the Plan will have the right to recover such payment from the Plan Participant or, if applicable, the Provider. As an alternative, the Plan reserves the right to deduct from any pending Claim for payment under this Benefit Plan any amounts the Plan Participant or Provider owes the Plan.

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

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

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

#### **R. Liability of Plan Affiliates**

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

#### **S. Out-of-Area Services**

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

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

##### **1. BlueCard® Program**

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

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

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to the Plan.

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

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

## 2. Medicare Supplemental/Medigap/Medicare Complementary

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

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

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

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

### a. Plan Participant Liability Calculation

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

### b. Exceptions

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

bills and payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

c. Medigap/Medicare Supplemental/Medicare Complementary Plans

Under Medigap/Medicare Supplemental/Medicare Complementary plans, when the Plan Participant receives treatment from a healthcare Provider that does not participate with the Host Blue, but does accept Medicare assignment, the amount the Plan Participant pays for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the healthcare Provider does not accept Medicare assignment, the Plan Participant may be liable for the difference between the amount that the Provider bills and the Medicare limiting charge, which will include the payment the Plan will make for the Covered Services as set forth in this paragraph. If the Plan Participant has additional benefits for healthcare services which Medicare would not otherwise cover, the amount the Plan Participant pays for such services 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, the Plan Participant may be liable for the difference between the amount that the Non-Participating healthcare Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

4. Out-of-Area Claims: Non-Participating Providers Plan Participant Liability Calculation - Emergency Care

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

**T. Certificates of Creditable Coverage**

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

**U. Continued Coverage During a Leave of Absence**

1. Family Medical Leave

The Plan will continue coverage for an Employee during any leave of absence the Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 (FMLA) and any amendments or successor provisions, as long as eligibility criteria under the law continues to be met. If Employee's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, Employee is entitled to re-enroll for coverage, so long as the Group maintains coverage with Company. If the Employee is not restored to active full-time employment by the end of the leave of absence period, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in "Termination of a Plan Participant's Coverage."

2. Disability Leave

When an Employee is not actively at work due to a health condition, Plan will maintain coverage for the Employee and any Dependents, as long as the Employee remains a bona fide Employee of the Group and premiums are paid.

If Group terminates Employee's employment, the Employee will cease to be eligible and coverage for the Employee and any Dependents will terminate as described in "Termination of a Plan Participant's Coverage."

3. Other Employer-Approved Leave of Absence



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

## **V. Compliance with HIPAA Privacy Standards**

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

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

### **1. General**

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

### **2. Permitted Uses and Disclosures**

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

### **3. Authorized Employees**

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

- a. **Updates Required.** The Employer shall amend the plan promptly with respect to any changes in the Plan Participants of its workforce who are authorized to receive Protected Health Information.
- b. **Use and Disclosure Restricted.** An authorized Plan Participant of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.
- c. **Resolution of Issues of Noncompliance.** In the event that any Plan Participant of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to a privacy official. The privacy official shall take appropriate action, including:

- (1) investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- (2) applying appropriate sanctions against the persons causing the breach, which depending upon the nature of the breach, may include oral or written reprimand, additional training or termination of employment;
- (3) mitigating any harm caused by the breach, to the extent practicable; and
- (4) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

#### 4. Certification of Employer

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

- a. not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
- b. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other Benefit or Employee Benefit Plan of the Employer;
- d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- e. make available Protected Health Information to individual Plan Participants in accordance with Section 164.524 of the Privacy Standards;
- f. make available Protected Health Information for amendment by individual Plan Participants and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- g. make available Protected Health Information required to provide any accounting of disclosures to individual Plan Participants in accordance with Section 164.528 of the Privacy Standards;
- h. make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- i. if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- j. ensure the adequate separation between the Plan and Plan Participants of the Employer's workforce, as required by Section 164.504 (f)(2)(iii) of the Privacy Standards.

The following Plan Participants of the Galliano Marine Service, LLC workforce are designated as authorized to receive Protected Health Information from Chouest Group Health Plan ("the Plan") in order to perform their duties with respect to the Plan: Norma Bonvillain, Group Health Employee Advocate, Dionne Chouest Austin, General Counsel, and Broker.

#### **W. Compliance with HIPAA Electronic Security Standards**

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

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. “Electronic Protected Health Information” shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards sections (3) Authorized Employees and (4) Certification of Employers described above in this Article.

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

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

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

In addition to the right to Appeal, the Plan Participant’s Provider is given an opportunity to speak with a Medical Director for Informal Reconsideration of the Claims Administrator’s coverage decisions concerning Medical Necessity or Investigational determinations.

The Plan Participant may also have the right to review their file and present evidence or testimony as part of the internal Claims and Appeals process.

An Expedited Appeal process is available for situations where the time frame of a standard Appeal would seriously jeopardize the life or health of a covered person, jeopardize the covered person’s ability to regain maximum function, or where in the opinion of the treating Physician, the covered person may experience pain that cannot be adequately controlled while awaiting a standard Appeal decision.

The Claims Administrator will respond to your Appeal request within the timeframes allowed by law. The Appeal response will provide information sufficient to identify the Claim and include the following:

### **A. Complaint and Grievance Procedures**

A quality of service concern addresses the Claims Administrator’s services, access, availability or attitude and those of the Claims Administrator’s Network Providers. A quality of care concern addresses the appropriateness of care given to a Plan Participant.

#### **1. To Register a Complaint**

A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Call the Claims Administrator’s customer service department at 1-800-599-2583 or 1-225-291-5370 to register a Complaint. The Claims Administrator will attempt to resolve a Plan Participant’s Complaint at the time of their call.

## 2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with the Claims Administrator or with services rendered by a Provider. If a Plan Participant does not feel their Complaint was adequately resolved or the Plan Participant wishes to file a formal Grievance, the Plan Participant must submit this in writing within 180 days of the event that led to the dissatisfaction. The Claims Administrator's customer service department will assist the Plan Participant if necessary. Send written Grievances to:

Blue Cross and Blue Shield of Louisiana  
Appeals and Grievance Unit  
P. O. Box 98045  
Baton Rouge, LA 70898-9045

A response will be mailed to the Plan Participant within thirty (30) business days after the Claims Administrator receives the written Grievance.

## 3. Informal Reconsideration

An Informal Reconsideration is an authorized Provider's telephone request to speak to the Claims Administrator's Medical Director or a peer reviewer on the Plan Participant's behalf about a Utilization Management decision the Claims Administrator has made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

Informal Reconsideration is available only for initial determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. The Claims Administrator will conduct an Informal Reconsideration within one (1) working day of the receipt of the request.

## **B. Appeal Procedures**

Plan Participants are offered two (2) levels of Appeal. The second level of Appeal is voluntary and will be handled by the Group. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Plan Participant's decision whether or not to submit to this voluntary level of review will have no effect on his rights to any other Benefits under the plan. No fees or costs will be imposed on the Plan Participant.

As a member of an ERISA Group, the Plan Participant is required to complete the mandatory first level of Appeal prior to instituting any civil action against the Group under ERISA section 502(a).

**MULTIPLE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED AT ANY LEVEL OF REVIEW.**

If the Plan Participant has questions or needs assistance putting the Appeal in writing, the Plan Participant may call the Claims Administrator's customer service department at 1-800-599-2583 or 1-225-291-5370.

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

## **C. Appeal Process**

The Claims Administrator will distinguish the Plan Participant's Appeal as either an administrative Appeal or a medical Appeal. Each type of Appeal has two (2) levels, including review by a committee at the second level for administrative Appeals. The second level for medical Appeals is handled by the Plan Administrator, Galliano Marine Services. Plan Participants are encouraged to submit written comments, documents, records, and other information relating to the Claim for Benefits. Upon request by the Plan Participant and free of charge, the Claims Administrator will provide reasonable access to and copies of all documents, records, and other information relevant to the Plan Participant's Claim for Benefits.

The Plan Participant has the right to appoint an authorized representative to represent the Plan Participant in their Appeals. An authorized representative is a person to whom the Plan Participant has given written consent to represent the Plan Participant in an Appeal of an Adverse Determination. The authorized

representative may be the Plan Participant's treating Provider, if the Plan Participant appoints the Provider in writing. The Provider must agree and waive, in writing, any right to payment from the Plan Participant other than any applicable Copayment, Deductible and/or Coinsurance amount.

Persons not involved in the previous decision regarding the Plan Participant's Claim will decide all Appeals. A Physician or other health care professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the Plan Participant's Claim, will review Medical Necessity Appeals.

## 1. Administrative Appeals

Administrative Appeals involve contractual issues other than Medical Necessity or Investigational denials and those denials that do not require medical judgment. Examples include Adverse Determinations based on Benefit Plan limitations or exclusions and Rescissions of coverage. Administrative Appeals should be submitted in writing to:

Blue Cross Blue Shield of Louisiana  
Appeals and Grievance Unit  
P. O. Box 98045  
Baton Rouge, LA 70898-9045

### a. First Level Administrative Appeals

If the Plan Participant is not satisfied with the Claims Administrator's denial of services, the Plan Participant, his authorized representative, or a Provider authorized to act on the Plan Participant's behalf, must submit a written request to Appeal within one hundred eighty (180) days following receipt of an initial Adverse Determination. Requests submitted to the Claims Administrator after one hundred eighty (180) days of the initial denial will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. If the original decision is changed at the Appeal level, the Claims Administrator will process the Plan Participant's Claim and notify the Plan Participant and all appropriate Providers, in writing, of the first level administrative Appeal decision. If the Plan Participant's Claim is denied on Appeal, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, of the decision within thirty (30) calendar days of the Plan Participant's request, unless We mutually agree that an extension of the time is warranted. At that time, the Claims Administrator will inform the Plan Participant of the right to begin the second level administrative Appeal process.

### b. Second Level Administrative Appeals

Not applicable to a Rescission of coverage Appeal, which follows the second level medical or Rescission Appeal track.

Within sixty (60) calendar days of the date of the first level administrative Appeal decision, a Plan Participant who is not satisfied with the decision may initiate, with assistance from the customer service department, if necessary, the second level of administrative Appeal process. Requests submitted to the Claims Administrator after sixty (60) days of the denial will not be considered.

A Plan Participant Appeals Committee not involved in any previous denial will review all second level administrative Appeals. The Committee's decision is final and binding as to any administrative Appeal and will be mailed to the Plan Participant within five (5) days of the Committee meeting.

## 2. Medical Appeals

Medical Appeals involve a denial or partial denial of services based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or when a service is determined to be experimental or Investigational.

### a. First Level Medical Appeals

If the Plan Participant is not satisfied with the Claims Administrator's denial of services, the Plan Participant, their authorized representative, or a Provider acting on their behalf, must submit a written request to Appeal within one hundred eighty (180) days following the Plan Participant's receipt of an initial Adverse Determination. Medical Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana  
Medical Appeals  
P. O. Box 98022  
Baton Rouge, LA 70898-9022

Requests submitted to the Claims Administrator after one hundred eighty (180) days of the denial will not be considered.

The Claims Administrator will investigate the Plan Participant's concerns. All Appeals of Medical Necessity denials will be reviewed by a Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. If the initial denial is overturned on the Plan Participant's medical Appeal, the Claims Administrator will process the Claim and will notify the Plan Participant and all appropriate Providers, in writing, of the first level Appeal decision. If the initial denial is upheld, the Claims Administrator will notify the Plan Participant and all appropriate Providers, in writing, of the decision and advise the Plan Participant of their right to submit a request for second level Appeal to the Plan Administrator. The decision will be mailed within thirty (30) days of the Plan Participant's request, unless the Plan Participant, their authorized representative and the Claims Administrator mutually agree that an extension of the time is warranted.

b. Second Level Medical or Rescission Appeal

If the Plan Participant disagrees with the first level medical Appeal determination, the Plan Participant or their authorized representative may request a second level medical Appeal. Within sixty (60) days of receipt of the first level decision, the Plan Participant must send his written request to:

Galliano Marine Services, LLC  
Attention: Dionne Chouest  
16201 East Main Street  
Cut Off, LA 70345

Requests submitted to the Plan Administrator after sixty (60) days of receipt of the first level Appeal decision will not be considered.

Requests submitted to the Claims Administrator will be forwarded to the Galliano Marine Services. The Plan Administrator has full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Plan.

3. Expedited Appeals

The Claims Administrator provides an Expedited Appeal process for review of an Adverse Determination involving a situation where the time frame of the standard Appeal would seriously jeopardize the Plan Participant's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Plan Participant may experience pain that cannot be adequately controlled while awaiting a standard Appeal decision. In these cases, the Claims Administrator will make a decision no later than seventy-two (72) hours of receipt of an Expedited Appeal request that meets the criteria for Expedited Appeal.

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

should be made to:

Blue Cross and Blue Shield of Louisiana  
Expedited Appeal - Medical Appeals  
P. O. Box 98022  
Baton Rouge, LA 70898-9022  
1-800-599-2583 or 1-225-291-5370

**ARTICLE XXII. CARE WHILE TRAVELING,  
MAKING PLAN CHANGES, AND FILING CLAIMS**

The Claims Administrator is continuing to update its online access for Plan Participants. Plan Participants may now be able to perform many of the functions described below, without contacting the Claims Administrator's customer service department. The Claims Administrator invites Plan Participants to log on to [www.bcbsla.com](http://www.bcbsla.com) for access to these services.

All of the forms mentioned in this section can be obtained from the Employer's personnel office, from one of the Claims Administrator's local service offices, or from the home office of Blue Cross and Blue Shield of Louisiana. If the Plan Participant needs to submit documentation to the Claims Administrator, the Plan Participant may forward it to Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Plan Participant has any questions about any of the information in this section, the Plan Participant may speak to his Employer or call the Claims Administrator's customer service department at the telephone number shown on his ID card.

**A. How to Obtain Care While Traveling**

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

1. In an Emergency, go directly to the nearest Hospital.
2. Call BlueCard Access at 1-800-810-BLUE (2583) for information on the nearest Preferred Network doctors and Hospitals.
3. Use a designated Preferred Network Provider to receive the highest level of Benefits.
4. Present the Plan Participant's ID card to the doctor or Hospital, who will verify coverage and file Claims for the Plan Participant.
5. The Plan Participant must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

**B. Adding or Changing the Plan Participant's Family Members on the Plan**

The Schedule of Eligibility lets the Plan Participant know when it is necessary to enroll additional family members for Dependent coverage under the Plan. Please read the Schedule of Eligibility Article and this section as they contain important information for the Plan Participant.

Group requires the Plan Participant to contact their Benefits Administrator to add newborn children, newborn adopted children, a spouse, or other Dependents not listed on the Plan Participant's original application for coverage. Plan should receive the Plan Participant's completed request from the Benefits Administrator within sixty (60) days of the child's birth or placement, or the Plan Participant's marriage.

The Schedule of Eligibility explains when coverage becomes effective for new family members.

**C. How to File Claims for Benefits**

The Claims Administrator and most Providers have entered into agreements that eliminate the need for a Plan Participant to personally file a Claim for Benefits. Preferred Network Providers or Participating Providers will file Claims for Plan Participants either by mail or electronically. In certain situations, the Provider may request the Plan Participant to file the Claim. If the Plan Participant's Provider does request the Plan Participant to file directly with the Claims Administrator, the following information will help the Plan Participant in correctly completing the claim form.

The Plan Participant's ID card shows the way the name of the Employee (Plan Participant of the Group) appears on the Claims Administrator's records. (If the Plan Participant has Dependent coverage, the name(s) are recorded as shown on the enrollment information the Plan received.) The ID card also lists the Plan Participant's Contract number (ID #). This number is the identification to the Plan Participant's membership records and should be provided to the Claims Administrator each time a Claim is filed. To assist in promptly handling the Plan Participant's Claims, the Plan Participant must be sure that:

1. an appropriate Claim form is used
2. the contract number (ID #) shown on the form is identical to the number on the ID card
3. the patient's date of birth is listed
4. the patient's relationship to the Employee is correctly stated
5. all charges are itemized, whether on the claim form or on the attached statement
6. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form
7. the date of service (Admission to a Hospital or other Provider) or date of treatment is correct
8. the Provider includes a diagnosis and procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)
9. the Claim is completed and signed by the Plan Participant and the Provider.

**IMPORTANT NOTE:** The Plan Participant must be sure to check all Claims for accuracy. The Contract number (ID #) must be correct. It is important that the Plan Participant keep a copy of all bills and Claims submitted.

#### **D. Filing Specific Claims**

1. Admission to a Hospital or Allied Health Facility Claims

When a Plan Participant or an enrolled family member is being admitted to a Preferred Network Provider or Participating Provider facility, the Plan Participant should show his ID card to the admitting clerk. The Provider will file the claim with the Claims Administrator. The Plan's payments will go directly to the Preferred Network Provider or Participating Provider. The Provider will then bill the Plan Participant directly for any remaining balance. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

2. Outpatient Department Claims

The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility. However, in some instances involving Outpatient treatment, the Provider may ask for payment directly from the Plan Participant. If this occurs, the Plan Participant should obtain an itemized copy of the bill, be sure the Claim form correctly notes the contract number (ID #), the patient's date of birth, as well as the patient's relationship to the Employee. The Provider must mark the statement or Claim form PAID. This statement should then be sent to the Claims Administrator.

4. Emergency Room Claims

When a Plan Participant has Emergency Room services performed by a Network or Non-Network Provider, the Plan Participant should show their Blue Cross and Blue Shield ID card to the admitting



clerk. The Provider will file the Claim with Us. Benefit payment will be sent directly to the Provider. The Plan Participant will receive an Explanation of Benefits after the Claim has been processed.

5. Nursing Services Claims

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

5. Durable Medical Equipment (DME) Claims

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

5. Mental Health and/or Substance Abuse Claims

For help with filing a Claim for Mental Health and/or Substance Abuse, the Plan Participant should refer to his ID card or call the Claims Administrator's customer service department.

6. Other Medical Claims

When the Plan Participant receives other medical services (clinics, Provider offices, etc.), he should ask if the Provider is a Preferred Network Provider or Participating Provider. If yes, this Provider will file the Plan Participant's Claim with the Claims Administrator. In some situations, the Providers may request payment and ask the Plan Participant to file. If this occurs, the Plan Participant must be sure the Claim form is complete before forwarding to the Claims Administrator. If the Plan Participant is filing the Claim, the Claim must contain the itemized charges for each procedure or service.

NOTES: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills. Itemized bills submitted with Claim forms must include the following:

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

**D. If Plan Participant Has a Question About His Claim**

Plan Participants can view information about the processing or payment of a claim online at [www.bcbsla.com](http://www.bcbsla.com).

If a Plan Participant has a question about the payment of a Claim, the Plan Participant can write to the Claims Administrator at the address below or the Plan Participant may call the Claims Administrator's customer service department at the telephone number shown on his ID card or any of the Claims Administrator's local service offices\*. If the Plan Participant calls for information about a Claim, the Claims Administrator can help the Plan Participant better if the Plan Participant has the information at hand, particularly the contract number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana,  
PO Box 98029

Remember, the Plan Participant must ALWAYS refer to the his contract number in all correspondence and recheck it against the contract number on his ID card to be sure it is correct.

\* Blue Cross and Blue Shield of Louisiana has local service offices located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

## **ARTICLE XXIII. RESPONSIBILITIES OF PLAN ADMINISTRATION**

### **A. Plan Administrator**

The Chouest Group Health Plan is the Benefit Plan of Galliano Marine Services, LLC, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Galliano Marine Services, LLC to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Galliano Marine Services, LLC shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Benefit Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any Benefit under the terms of this Benefit Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any Benefits or making any Claim for Benefits under this Benefit Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and further constitutes agreement to the limited standard and scope of review described by this section.

Service of legal process may be made upon the Plan Administrator.

### **B. Duties of the Plan Administrator**

1. to administer the Plan in accordance with its terms;
2. to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
3. to decide disputes that may arise relative to a Plan Participant's rights;
4. to prescribe procedures for filing a Claim for Benefits and to review Claim denials;
5. to keep and maintain the Plan documents and all other records pertaining to the Plan;
6. to appoint a Claims Administrator to pay Claims;
7. to perform all necessary reporting as required by ERISA;
8. to establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609; and
9. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

### **C. Plan Administrator Compensation**

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

#### **D. Fiduciary**

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

##### **1. Fiduciary Duties**

A fiduciary must carry out his duties and responsibilities for the purpose of providing Benefits to the employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- a. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- b. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- c. in accordance with the Plan documents to the extent they agree with ERISA.

##### **2. The Named Fiduciary**

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- a. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- b. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

#### **E. The Claims Administrator is not a Fiduciary**

A Claims Administrator is NOT a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

### **ARTICLE XXIV.**

### **ERISA RIGHTS**

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

#### **A. Receive Information About the Plan and Benefits**

1. A Plan Participant may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including health benefit contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Upon written request to the Plan Administrator, a Plan Participant may obtain copies of documents governing the operation of the Plan, including health benefit contracts and collective bargaining

agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

3. A Plan Participant may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

## **B. Continue Group Health Plan Coverage**

A Plan Participant may continue health care coverage for himself, his spouse, or his Dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. The Plan Participant or Dependents may, however, have to pay for such coverage. A Plan Participant may also review this document and the Summary Plan Description governing the Plan on the rules pertaining to the Plan Participant's COBRA continuation of coverage rights.

## **C. Prudent Actions by Plan Fiduciaries**

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

This Benefit Plan will not discriminate on the basis of race, color, religion, national origin, disability, sex, gender identity, sexual orientation, age, protected veteran or disabled status or genetic information; and shall not impose eligibility rules or variations in Employee contributions or fees based on a Plan Participant's health status or a health status-related factor.

## **D. Enforce Participant's Rights**

1. If a Plan Participant's Claim for a Plan Benefit is denied or ignored, in whole or in part, the Plan Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.
2. Under ERISA, there are steps the Plan Participant can take to enforce the above rights. A Plan Participant must exhaust all Claims and Appeal procedures available to him before filing any suit. For instance, if the Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Plan Participant may file suit in Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Plan Participant up to \$110.00 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such Plan Participant may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Plan Participant is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person he has sued to pay these costs and fees. If the Plan Participant loses, the court may order him to pay these costs and fees, for example, if it determines that his Claim is frivolous.

## **E. Assistance With Participant Questions**

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

also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## GENERAL PLAN INFORMATION

**Name of Plan:** Chouest Group Health Plan

**Name and Address of Plan Sponsor:** Galliano Marine Services, LLC  
16201 East Main Street  
Cut Off, LA 70345

**Employer Identification Number (EIN):** 72-0722768

**Plan Number (PN):** 501

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

**Funding Medium and Type of Administration:** The Plan is a self-funded Group Health Plan. Benefits are administered, on behalf of the Plan Administrator, by Blue Cross and Blue Shield of Louisiana, pursuant to the terms of the Administration Services Agreement and the terms and conditions of the Benefit Plan.

**Name and Address of Plan Administrator:** Chouest Group Health Plan  
16201 East Main Street  
Cut Off, LA 70345  
985-601-4111

**Agent for Service of Legal Process:** Chouest Group Health Plan  
Attn: Dionne Chouest  
16201 East Main Street  
Cut Off, LA 70345  
985-601-4111

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

**Plan Details:** The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, denial, or loss of any Benefits are described in the Benefit Plan.

**Future of the Plan:** Although the Plan Sponsor expects and intends to continue the Benefit Plan indefinitely, the Group reserves the right to modify, amend, suspend, or terminate the Benefit Plan at any time.

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

**Department of Labor:** If You have any questions about Your rights under the Employee Retirement Income Security Act of 1974 (ERISA), You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your 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, DC 20210.



