

BENEFITS CHECKSHEET
FOR
ASO AND NON-STANDARD
FULLY INSURED BUSINESS



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross
and Blue Shield Association.

5525 Reitz Avenue • Baton Rouge, Louisiana • 70809-3802
www.bcbsla.com

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GROUP INFORMATION

Existing Group

Group Number: _____

Original Effective Date: _____ Amended Effective Date: _____

New Group

Effective Date: _____

Group's Account Executive: _____

BCBSLA Service Representative: _____

Broker/Consultant: _____

Group Name: _____

Official Plan Name: _____

Physical Address: _____

Mailing Address: _____

Group Contact: _____ Title: _____

Phone Number: _____ Email Address: _____

Fax Number: _____

ERISA Group: Yes No

Number of Employees: _____

PRODUCT INFORMATION

Dual Option Medical: Yes No

Medical: Blue Saver PPO HMO HMOPOS Premier Blue

Dental: Yes No Stand Alone Document Incorporated with Health Plan
If yes, please complete section in the Application for Group Coverage Form.

Will medical deductible credit from the previous carrier or TPA be applied to the BCBSLA product?

Yes No

NOTE: Deductible credit for group enrolling with an effective date during the last quarter (Oct, Nov, Dec) of the year will not be applied, unless claims are to be paid, due to carryover deductible provisions, thus giving deductible credit the following plan year for calendar year benefits.

Underwriting: _____ Date: _____

Group's Account Executive: _____ Date: _____

BCBSLA Account Executive: _____ Date: _____

ELIGIBILITY REQUIREMENTS

Does Group want to duplicate current eligibility? Yes No If yes, please attach prior plan language.

Date of Employment First Billing Date on or after date of employment

Eligible to enroll _____ months following date of employment.

Other: _____

Eligible Dependents:

- Legal Spouse Foster Children
- Unmarried Child Stepchild
- Grandchild (in legal custody) Child placed for adoption
- Domestic Partner, ASO Only (Group must provide eligibility requirements for domestic partners and dependents of domestic partners)
- Other, please explain: _____

Child from birth to age _____, regardless of student status.

Unmarried child covered until age _____. If full-time student, dependent child covered until age _____.

Coverage ends: On birthday End of month following birthday

Retirees Covered? Yes No If yes, please provide definition.

Definition of Retiree: _____

Officers/Board of Directors Covered? Yes No If yes, please provide definition.

Definition of Officer/Board of Directors: _____

Elected Officials Covered? (Applies to School Board and Governmental Entities only)

Yes No If yes, please provide definition.

Definition of Elected Official: _____

Applicable for School Board Groups only:

All School Board Groups must follow the eligibility and continuation of coverage guidelines as mandated by the State Employees Group Benefits Program, including definitions, pre-existing condition exclusion provisions, and special enrollment provisions.

ELIGIBLE MEMBERSHIP CLASSES

	CURRENT	PROPOSED
Active		
Management		
Non-Management		
Retiree		
COBRA		
Sub. Out of Area		
Additional:		

PRE-EXISTING CONDITIONS

Standard Pre-existing Condition Requirements

Standard Pre-existing Condition Definition:

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

Standard Pre-existing Condition Exclusion:

Pre-Existing Conditions are not covered, subject to the following:

- a. Except for Mental Disorders, a Pre-Existing Condition exclusion is limited to a one hundred eighty (180) day period (eighteen (18) months for Late Enrollees), less the period of Creditable Coverage.
- b. A Pre-Existing Condition exclusion is limited to sixty (60) days for Mental Disorders, less the period of Creditable Coverage. **(State Mandate – Optional for ASO groups)**
- c. A Pre-Existing Condition exclusion cannot be applied to pregnancy.
- d. A Pre-Existing Condition exclusion cannot be applied to a newborn, an adopted child under the age of eighteen (18) or a child placed for adoption under the age of eighteen (18), if they are covered under Creditable Coverage within thirty (30) days of birth, adoption, or placement for adoption without a Significant Break in Coverage.
- e. a diagnosis is not necessary for a condition to be a Pre-Existing Condition.

No Pre-Existing Condition Exclusion Applicable

Other (As specified by group)

Comments: _____

HSA and HRA Information:

If applicable, will a Health Savings Account (HSA) be offered with the Blue Saver product? Yes No

HSA Administrator Name and Address: _____

Employer Contributions: Yes No If yes, indicate amount of contribution \$ _____

Will you be providing a Health Reimbursement Account (HRA)? Yes No

What medical plan will the HRA be offered in conjunction with? Yes No

HRA Administrator Name and Address: _____

Amount funded: _____

Blue Saver Benefits Information

Lifetime Maximum: \$5,000,000 Other: _____

Blue Saver PPO Deductible: Does the Deductible apply to eligible preventive/wellness care services?
 Yes No

	Deductible Amounts		Out of Pocket Amounts (Includes Deductible Amounts)	
	Single	Family	Single	Family
<input type="checkbox"/>	\$1000	\$2200	\$2100	\$4200
<input type="checkbox"/>	\$1700	\$3450	\$3450	\$6150
<input type="checkbox"/>	\$2500	\$5050	\$5050	\$6150
<input type="checkbox"/>	\$3000	\$6000	\$6000	\$10,000
<input type="checkbox"/>	\$5000	\$10,000	\$10,000	\$10,200
<input type="checkbox"/> Other*				
<input type="checkbox"/> Other*				

*Different deductible amounts than those listed above are subject to BCBSLA approval and IRS HDHP guidelines.

Blue Saver Coinsurance after Deductible:

	Preferred Care Network	All Other Providers
<input type="checkbox"/>	100% / 0%	80% / 20%
<input type="checkbox"/>	80% / 20%	60% / 40%
<input type="checkbox"/> Other*		

*Different coinsurance amounts than those listed above are subject to BCBSLA approval and IRS HDHP guidelines.

Blue Saver Prescription Drug Benefits:

	Generic Drugs	Brand – Name Drugs
<input type="checkbox"/>	100% / 0%	80% / 20%
<input type="checkbox"/>	80% / 20%	60% / 40%
<input type="checkbox"/> Other*		

Contraceptive Drugs: Covered Not Covered

Day Supply Limitations for Retail: 90 day supply Other _____

30 day supply dispensing limitation for Specialty Drugs: Yes No

For dispensing limitations go to www.bcbsla.com Yes No

Quantity Per Dispensing Limitations apply. Yes No

Prescription Drugs that Require Authorization:

Specialty Drugs/Biotechnology Medicines - Examples may include, but are not limited to:

- Growth Hormones*
- Anti Tumor Necrosis Factor Drugs*
- Intravenous Immune Globulin; Interferon*
- Monoclonal Antibodies*
- Hyaluronic Acid Derivatives For Joint Injection*
- Chemotherapeutic Drugs

*Shall include all drugs that are in this category.

Controlled Dangerous Substances Examples may include but are not limited to:

- Actiq®, OxyContin®

PPO Benefits Information

Lifetime Maximum: \$5,000,000 Other: _____

PPO Deductible:

Individual: \$_____ All Providers Combined or
 \$_____ Preferred Providers and \$_____ All Other Providers

Family: Select one of the following options:

- Not applicable
- Maximum of _____ individual deductibles per family each calendar year. A member is eligible for benefits after he/she has satisfied the individual deductible amount, or
- Aggregate amount per family each calendar year. Individual deductible amounts need not be met to satisfy the family aggregate amount. A member is eligible for benefits after he/she has satisfied the individual deductible amount.

\$_____ All Providers Combined or
\$_____ Preferred Providers and \$_____ All Other Providers

Does Deductible apply to:

- eligible preventive/wellness care services Yes No
- mandated benefits for hearing aids for covered members age 17 and under Yes No
- other: _____

Deductible Carryover: (Applies only to the Benefit Period Deductible)

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

PPO Inpatient Hospital Deductible:

- \$_____ for each admission. This amount is in addition to the calendar year deductible. The calendar year deductible is not reduced by this amount.
- Not applicable

PPO Coinsurance:

Preferred Providers of the Preferred Care Network:

_____% / _____% Up to the Out-of Pocket Amount per Benefit Period, then 100% for the remainder of that Benefit Period up to the Lifetime Maximum.

All Other Providers: (Participating and Non-Participating)

_____% / _____% Up to the Out-of Pocket Amount per Benefit Period, then 100% for the remainder of that Benefit Period up to the Lifetime Maximum.

Thirty percent (30%) Non-Participating Hospital Penalty (reduction in payment):

- Yes No (If no, reinsurer approval required)

Out of Pocket Amount:

- Does not include Benefit Period Deductible Includes Benefit Period Deductible

Individual: \$_____ All Providers Combined or
\$_____ Preferred Providers and \$_____ All Other Providers

Family: \$_____ All Providers Combined or
\$_____ Preferred Providers and \$_____ All Other Providers

Physician Office Visit Copayment: Not applicable Preferred Providers: \$_____ per visit

When the services shown below are performed in the physician's office by an eligible Preferred Provider of the Preferred Care Network, the deductible and coinsurance are not applicable for the eligible services listed below. All Other Providers: All eligible services are subject to the deductible and coinsurance.

1. This provision is not applicable for any services eligible under the preventive or wellness program.
2. Any other services performed during the visit are subject to the deductible and coinsurance.
3. Copayment services means the following Outpatient services when rendered in a Physician's, Optometrist's, podiatrist's, or chiropractor's office or clinic, or when rendered in an Urgent Care Center or federally qualified rural health clinic:
 - a. office visit charges and consultation;
 - b. x-rays;
 - c. laboratory tests. Laboratory tests that are processed and completed within the Physician's or Optometrist's office or clinic will be subject to the Physician office visit Copayment. Laboratory tests that are sent out of the Physician's or Optometrist's office or clinic for processing may be subject to the Deductible Amount and Coinsurance;
 - d. machine tests;
 - e. injections, allergy serums, and vials of allergy medications;
 - f. surgical procedures;
 - g. radiation treatments obtained in Physician's office;
 - h. Mental Disorders; and/or
 - i. alcohol and/or drug abuse (if covered).
4. Copayment services do not include the following services and/or supplies. The following services and/or supplies are subject to the Benefit Period Deductible Amount and applicable Coinsurance percentage shown in the Schedule of Benefits:
 - a. allergy testing;
 - b. Physical Therapy, Occupational Therapy, and Speech Therapy;
 - c. Prescription Drugs;
 - d. Preventive or Wellness Care; and/or
 - e. medical and surgical supplies.

Accidental Injury Benefits:

- Not applicable
 \$350.00 Per member, per accident, per benefit period
 \$_____ Per member, per accident, per benefit period

If a Member incurs medical expenses for treatment or services as a direct result of a traumatic bodily injury sustained solely by accidental means, Group agrees to pay one hundred percent (100%) of the Allowable Charge for such medical expenses actually incurred up to the maximum amount per Benefit Period shown above. Once the maximum is exhausted, the Benefit Period Deductible Amount will apply and regular Benefits will be provided to the Member.

HMO and HMOPOS Benefits Information

Lifetime Maximum: \$5,000,000 Other: _____

Deductible: Not applicable to Network Benefits

Individual

Non-Network HMOPOS Only: \$ _____
Dependent Out-of-Area: \$ _____

Family

Non-Network HMOPOS Only: \$ _____
Dependent Out-of-Area: \$ _____

Deductible Carryover: (Applies only to the Benefit Period Deductible)

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

HMO and HMOPOS Coinsurance:

Network Only: (Services not covered by a Copayment)

_____ % / _____ % Up to the Out-of Pocket Amount per Benefit Period, then 100% for the remainder of that Benefit Period up to the Lifetime Maximum.

Non-Network HMOPOS Only:

_____ % / _____ % Up to the Out-of Pocket Amount per Benefit Period, then 100% for the remainder of that Benefit Period up to the Lifetime Maximum.

Dependent Out-of-Area:

_____ % / _____ % Up to the Out-of Pocket Amount per Benefit Period, then 100% for the remainder of that Benefit Period up to the Lifetime Maximum.

Out of Pocket Amount: Does not include Benefit Period Deductible

Individual

Network: \$ _____
Non-Network HMOPOS Only: \$ _____
Dependent Out-of-Area: \$ _____

Family Aggregate

Network: \$ _____
Non-Network HMOPOS Only: \$ _____
Dependent Out-of-Area: \$ _____

Copayments (Copay): Applies to Network Providers only unless otherwise noted below.

Primary Care Physician (PCP) Office Visit Copay: \$ _____

PCP copayment includes physician specialties for General Practice, Family Practice, Pediatrics and Internal Medicine. Also applies to Allied Health Provider Office Visits for Chiropractic, Physician Assistant, Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation.

Specialist Office Visit Copay: \$ _____

Copay includes all physicians and allied health professionals not covered by PCP Office Visit Copay.

Vision Care Exam Copay: \$ _____

Copay applies to Network and Dependent Out-of-Area Benefits. Non-network subject to deductible and coinsurance.

- Limited to one visit every 24 months.
- Covered, limited to (_____) visits per member every (_____) months.

Urgent Care Center Copay: \$ _____

Emergency Room Copay: \$ _____ Network and Out-of-Area Emergency

Ambulance Copay: \$ _____

Ambulatory Surgery Copay: \$ _____

Inpatient Hospital Copay: \$ _____ Per day for the first _____ days of inpatient admission

Pregnancy Care Copay: \$ _____

Durable Medical Equipment, Prosthetic Appliances, Orthotic Devices, X-ray, Laboratory Services, Home Health, Hospice, Skilled Nursing, Inpatient and Outpatient Professional Services, and all other services for which a copay does not apply are subject to applicable deductible and coinsurance amounts.

Pregnancy Care Copay: \$_____

Durable Medical Equipment, Prosthetic Appliances, Orthotic Devices, X-ray, Laboratory Services, Home Health, Hospice, Skilled Nursing, Inpatient and Outpatient Professional Services, and all other services for which a copay does not apply are subject to applicable deductible and coinsurance amounts.

Prescription Drug Benefits (PPO, HMO, HMOPOS, and Premier Blue)

Prescription Drug Benefits: Included Excluded

Administered by: BCBSLA HMOLA Other

If Other, Drug Administrator Name and Address: _____

Prescription Drug Deductible (if applicable): \$_____

Prescription Drug Copayment:

\$8/\$15/\$30/\$45/\$50 \$10/\$20/\$35/\$50/\$50 \$15/\$25/\$40/\$55/\$50

\$8/\$15/\$35/\$50/\$50 \$10/\$20/\$40/\$55/\$50 \$15/\$25/\$45/\$60/\$50

\$15/\$25/\$50/\$65/\$50 Other _____

Retail: 30 day supply Other _____

Mail Order: 90 day supply Other _____

Contraceptive Drugs: Covered Not Covered

30 day supply dispensing limitation for Specialty Drugs: Yes No

For dispensing limitations go to www.bcbsla.com Yes No

Quantity Per Dispensing Limitations apply. Yes No

Prescription Drugs that Require Authorization:

Specialty Drugs/Biotechnology Medicines - Examples may include, but are not limited to:

- Growth Hormones*
- Anti Tumor Necrosis Factor Drugs*
- Intravenous Immune Globulin; Interferon*
- Monoclonal Antibodies*
- Hyaluronic Acid Derivatives For Joint Injection*
- Chemotherapeutic Drugs

*Shall include all drugs that are in this category.

Controlled Dangerous Substances – Examples may include but are not limited to:

- Actiq®, OxyContin®

Special Prescription Drug Benefits as defined by the Group: _____

Benefit Information for all Products

Mental Disorders: Administered by: BCBSLA HMOLA Other

If Other, Name Administrator: _____

Inpatient Maximum: Two days of partial hospitalization program (PHP) or 2 days of residential treatment center hospitalization may be traded for each available Inpatient day that is available up to the maximum.

Same as any other illness: Yes No (If know, indicate amounts below)

Combined with Alcohol and/or Drug Abuse: Yes No

45 days per benefit period. _____ days per benefit period

Outpatient Maximum: Each day of treatment in intensive outpatient program (IOP) will be counted as 1 outpatient visit

Combined with Alcohol and/or Drug Abuse: Yes No

52 visits per benefit period. _____ visits per benefit period.

Mental Disorders Coinsurance: Same as Medical Insurance

Alcohol and/or Drug Abuse: Administered by: BCBSLA HMOLA Other

If Other, Name Administrator: _____

Inpatient Maximum: Two days of partial hospitalization program (PHP) or 2 days of residential treatment center hospitalization may be traded for each available Inpatient day that is available up to the maximum.

Same as any other illness: Yes No (If know, indicate amounts below)

Combined with Mental Disorders: Yes No

7 days per Benefit Period. _____ days per Benefit Period

Outpatient Maximum: Each day of treatment in intensive outpatient program (IOP) will be counted as 1 outpatient visit.

Combined with Mental Disorders: Yes No

20 visits per Benefit Period _____ visits per Benefit Period

Alcohol and/or Drug Coinsurance: Same as Medical Insurance

Organ, Tissue, and Bone Marrow Transplant:

Lifetime Maximum for all approved transplant procedures is including services related or required as a result of the transplant procedure.

Same as any other illness \$ _____ Lifetime Maximum

NOTE: A separate lifetime maximum may be applied to Dependent Out-of-Area benefits on HMO and HMOPOS.

Acquisition Expense Maximum:

\$50,000.00 per Lifetime all covered Transplants

\$50,000.00 per covered transplant

\$ _____ Other

No separate maximum is applicable.

Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances (Aggregate):

Benefits are limited to:

\$25,000.00 or \$ _____ per member each Benefit Period, all services combined

Same as any other illness

Rehabilitative Care Benefits (Physical, Occupational and Speech Therapy, Chiropractic services):

Same as any other illness (standard)

Other as specified by the group:

Outpatient Speech Therapy (including developmental speech therapy):

- Covered, no limitation applicable
- Covered, limited to \$2,500.00 or (\$ _____) per member each Benefit Period, all services combined

Physical and Occupational Therapies Combined:

- Covered, no limitation applicable
- Covered, limited to \$2,500.00 or (\$ _____) per member each Benefit Period, all services combined

Skilled Nursing Facility:

- Covered, no limitation applicable
- Covered, limited to (_____) visits per member each benefit period

Home Health Care:

- Covered, no limitation applicable
- Covered, limited to (_____) visits per member each benefit period

Hospice Care:

- Covered, no limitation applicable
- Covered, limited to (_____) visits per member each benefit period

Private Duty Nursing:

- Outpatient services only Inpatient and outpatient services are covered

Benefits for eligible authorized services are limited to a maximum payment of:

- Limited to \$5,000.00 or (\$ _____) per member each Benefit Period
- Same as any other illness

Pregnancy Benefits:

Minor Dependents Covered: Yes No

Oral Surgery Coverage Under Major Medical: Not Covered Covered as shown below

Coverage is provided only for the following procedures or services:

- Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- Excision of impacted teeth (Not applicable to HMO products)
- 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.)
- Excision of exostoses or tori of the jaws and hard palate.
- Incision and drainage of abscess and treatment of cellulitis.
- Incision of accessory sinuses, salivary glands, and salivary ducts.
- Anesthesia for the above services or procedures when rendered by an oral surgeon.
- Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia benefits are not available for treatment rendered for Temporomandibular Joint (TMJ) Disorders.

Preventive and Wellness Care: (PPO and BlueSaver) State Mandated Benefits:

If a Member receives Covered Services from a Preferred Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge. When Preventive or Wellness Care services are rendered by any Provider who is not a Preferred Provider, Benefits will be subject to normal coinsurance amounts.

1. Immunizations
 - a. 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).
 - b. Immunizations recommended by the Member's Physician.

2. One (1) mammography examination every twelve (12) months, or more frequently if recommended by the Member's Physician or gynecologist/obstetrician.
3. One (1) routine physical examination per Member per Benefit Period, including related diagnostic tests performed during the same visit.
4. Well Baby Care.
5. 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 applies to all but the first visit.
6. One (1) routine Pap smear per Benefit Period.
7. One (1) digital rectal exam and prostate-specific antigen (PSA) test per Benefit Period, is covered for Members fifty (50) years of age or older, and as recommended by a Physician if the Member 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 visit and recommended by a Physician.
8. Hemoccult (colon) test, limited to one (1) per Benefit Period.

Other Preventive and Wellness Care: (List) _____

Preventive and Wellness Care: (HMO and HMOPOS) State Mandated Benefits

The Member must pay all Copayments, any applicable Deductible Amounts and Coinsurance percentages.

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

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

B. Physical Examinations - Network Benefits and Dependent Out-of-Area Benefits only for both HMO and HMOPOS:

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

C. Immunizations - Network Benefits and Dependent Out-of-Area Benefits on HMO and HMOPOS, Non-Network available on HMOPOS:

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

D. Other Wellness Services - Network Benefits and Dependent Out-of-Area Benefits on HMO and HMOPOS, Non-Network available on HMOPOS:

1. Digital rectal examination and prostate-specific antigen (PSA) test limited to one (1) per Benefit Period, is covered for Members, fifty (50) years of age or older, and as recommended by his Primary Care Physician if the Member is over forty (40) years of age. A second visit shall be permitted if recommended by the Member's Primary Care Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits. The Deductible Amount does not apply.
2. Hemoccult (colon) test, limited to one (1) per Benefit Period.
3. Specific Preventive or Wellness Care services may be included or excluded from this Benefit if shown in the Schedule of Benefits.

Other Preventive and Wellness Care: (List) _____

Authorization of Admissions: (PPO, BlueSaver, and Premier Blue)

Authorization not requested (elective & emergency admits)

eligible inpatient hospital charges are subject to a **(\$1,000.00)** (\$_____) penalty. The penalty is applied prior to application of the deductible and coinsurance. This amount is not eligible for satisfying the out-of-pocket amount

OR

eligible inpatient hospital charges are subject to a _____% penalty

No Penalty

Authorization for Other Covered Services and Supplies: (PPO, BlueSaver, and Premier Blue)

NOTE: AUTHORIZATION OF SERVICES IS NOT A GUARANTEE OF PAYMENT.

The following services and supplies require Authorization prior to the services being rendered or supplies being received.

- Bone growth stimulator
 - CT Scans
 - Day Rehabilitation Programs
 - Electric & Custom Wheelchairs
 - Home Health Care
 - Hospice Care
 - Hyperbarics
 - Implantable Medical Devices over \$2000.00 such as Implantable Defibrillator and Insulin Pump
 - M.R.I./M.R.A.
 - Non-Emergency Air Ambulance
 - Nuclear Cardiology
 - PET/SPECT Scans
 - Prosthetic Appliances
 - Sleep Studies
 - Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
 - Vacuum Assisted Wound Closure Therapy
 - Other: (List) _____
-
-
-

Authorization of Admissions: (HMO and HMOPOS)

- For HMO all admissions must be authorized.
- For HMOPOS all admissions must be Authorized to receive Network Benefits.
- For Members enrolled for Dependent Out-of-Area Benefits, if Authorization of an Admission is not requested, the Member's claim may be reviewed for Medical Necessity. If it is determined that the Admission is not Medically Necessary, the Admission will not be covered and the Member must pay all charges.
- Requests for Authorization of all Admissions and for Concurrent Review of an Admission in progress must be made to HMO Louisiana, Inc. by calling 1-800-376-7741.
- If a request for Authorization or Concurrent Review is denied, the Admission will not be covered.

Authorization for Other Covered Services and Supplies: (HMO and HMOPOS)

NOTE: AUTHORIZATION OF SERVICES IS NOT A GUARANTEE OF PAYMENT.

The following Outpatient services and supplies require Authorization prior to services being rendered to receive Network Benefits.

- For HMO these services are not covered unless Authorization is obtained.
- For HMOPOS the following Outpatient services and supplies require Authorization prior to services being rendered to receive Network Benefits.
- Authorization is not required for Dependent Out-of-Area Benefits.
- Requests for Authorization must be made to HMO Louisiana, Inc. by calling 1-800-376-7741.
 - Alcohol and Drug Services
 - Bone growth stimulator
 - Cardiac Rehabilitation
 - CT Scans
 - Day Rehabilitation Programs
 - Dialysis
 - Durable Medical Equipment (Greater than \$300.00)
 - Electric & Custom Wheelchairs
 - Home Health Care
 - Hospice
 - Hyperbarics

- Implantable Medical Devices over \$2000.00 such as Implantable Defibrillator and Insulin Pump
 - Infusion Therapy not performed in a Physician's office, other than chemotherapy
 - Low Protein Food Products
 - Mental Health Services
 - M.R.I./M.R.A.
 - Non-Emergency Air Ambulance
 - Nuclear Cardiology
 - Oral Surgery
 - Orthotic Devices
 - All outpatient surgical procedures not performed in a Physician's office
 - All outpatient non-surgical procedures not performed in a Physician's office, other than x-ray and laboratory work
 - Outpatient Pain rehabilitation or pain control programs
 - PET/SPECT Scans
 - Private Duty Nursing
 - Prosthetic Appliances
 - Sleep Studies
 - Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
 - Vacuum Assisted Wound Closure Therapy
 - Other: (List) _____
-
-

BENEFITS MANDATED BY STATE OF LOUISIANA

The services listed below are mandated by the state of Louisiana and are optional for self-funded (ASO) accounts.

Ambulance:

Covered as shown below Not Covered

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

Other: _____

Cleft Lip/Cleft Palate: Covered as show below Not Covered

- oral and facial surgery, surgical management, follow-up care
- prosthetic appliances
- orthodontic treatment/management
- medically necessary preventive and restorative dentistry
- speech/language evaluation and therapy
- audiological assessments and amplification devices
- otolaryngology treatment and management
- genetic assessment and counseling for the patient and parents
- psychological assessment and counseling

Coverage for Diabetes: Covered as shown below Not Covered

Treatment or services must be prescribed by the member's physician and are limited to:

- one evaluation and training program per member not to exceed \$500.00 maximum payment
- additional training because of a significant change in the member's symptoms or condition is available

If approved by the member's physician, all services are limited to a maximum payment of \$100.00 per calendar year and \$2,000.00 per lifetime

Interpreter Training for the Hearing Impaired: Covered as shown below Not Covered

Include's benefits for a qualified interpreter/transliterator in connection with eligible medical treatment or diagnostic consultations

Attention Deficit/Hyperactivity Disorder:

Covered as shown below Not Covered Covered same as any other illness

Initial diagnosis:	\$600.00	Other: _____
Benefit Period Maximum:	\$2,500.00	Other: _____
Lifetime:	\$10,000.00	Other: _____

Clinical Trial Participation for Cancer: Covered as shown below Not Covered

- Treatment must be therapeutic or palliative for patients with cancer, or for the prevention or early detection of cancer
- Treatment/studies are provided in Phase II, III or IV approved clinical trials for cancer
- Treatment provided in accordance with clinical trials by approved entities and facilities

Bone Mass Measurement:

- Not Covered
- Covered as shown below

Include routine screening services for bone mass measurement for diagnosis and treatment of osteoporosis
Services are available for:

- estrogen deficient women at clinical risk of osteoporosis who are considering treatment,
- individuals receiving long term steroid therapy,
- individuals being monitored to assess the effectiveness of approved osteoporosis drug therapies.

Low Protein Food Products:

- Not covered
- Covered as shown below

Benefits for low protein food products are limited to a maximum payment of \$200 per month.

These supplies must be ordered by a physician for dietary treatment of certain metabolic diseases listed below:

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

LIMITATIONS AND EXCLUSIONS

Please review the following Limitations and Exclusions very carefully. All additions to this section or deletions from this section must be approved by us.

- A. Services, supplies and treatment for services that are not covered under this Benefit Plan and complications from services, supplies and treatment for services that are not covered under this Benefit Plan are excluded.
- B. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown in the Schedule of Benefits. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**
1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.
 2. Any charges exceeding the Allowable Charge.
 3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.
 4. Services, Surgery, supplies, treatment, or expenses:
 - a. other than those specifically listed as covered by this Benefit Plan or for which a Member has no obligation to pay, or for which no charge would be made if a Member had no health benefits coverage;
 - b. **[Fully Insured Only]** [rendered or furnished before the Member's Effective Date. Charges for Hospital services or supplies rendered or furnished during an Admission in progress on a Member's Effective Date are not covered, regardless of whether a Member's Admission continues after a Member's Effective Date, unless otherwise required by law. Hospital Benefits will be provided for an Admission in progress on the date a Member's coverage under this Benefit Plan ends, until the end of that Admission, or until a Member has reached any Benefit limitations set in this Benefit Plan, whichever occurs first;]
[ASO Only] [rendered or furnished before a Member's Effective Date. Charges for Hospital services or supplies rendered or furnished during an Admission in progress on a Member's Effective Date are not covered until 12:01 AM of the Member's Effective Date unless otherwise required by law. An Admission in progress on the date the Member's coverage under this Benefit Plan ends will be covered until the date that coverage ends. The Member will not receive Benefits for any charges incurred after the date coverage ends;]
 - c. which are not prescribed by or performed by or upon the direction of a Physician or Allied Health Professional acting within the scope of his license;
 - d. to the extent payment has been made or is available under any other contract issued by 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 Member has Medicare, except when Medicare Secondary Payer provisions apply;
 - f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;
 - g. rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of L.R.S. 23:1205(C);
 - h. received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group; or
 - i. ordered, prescribed, or rendered by a Provider who is related to a Member by blood, marriage or adoption, or who regularly resides in a Member's household.
 5. Services in the following categories:
 - a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;
 - b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;
 - c. those occurring as a result of taking part in a riot or acts of civil disobedience;
 - d. those occurring as a result of a Member's commission or attempted commission of a felony; or
 - e. for treatment of any Member confined in a prison, jail, or other penal institution.
 6. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**
 - a. rhinoplasty;
 - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
 - c. gynecomastia;

- d. Reconstruction after mastectomy on the same breast; surgery performed on the other breast to produce symmetrical appearance
FOR GROUPS WITH COVERAGE FOR BREAST REDUCTION:
 [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; and the patient is **not** more than thirty percent (30%) over ideal body weight; and the Member 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;
 - f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;
 - g. diastasis recti;
 - h. biofeedback;
 - i. lifestyle/habit changing clinics and/or programs;
 - j. treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies.
 - k. industrial testing or self help programs (including, but not limited to, smoking cessation programs and supplies, and stress management programs), work hardening programs and/or functional capacity evaluation; driving evaluations;
 - l. recreational therapy;
 - m. primarily to enhance athletic abilities; and/or
 - n. Inpatient pain rehabilitation and pain control programs.
7. Services, Surgery, supplies, treatment, or expenses related to:
- a. eyeglasses or contact lenses (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered in the Schedule of Benefits;
 - b. eye exercises, visual training, or orthoptics;
 - c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;
 - d. hair pieces, wigs, hair growth, and/or hair implants;
 - e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
 - f. visual therapy.
8. Services, Surgery, supplies, treatment or expenses related to:
- a. any costs of donating an organ or tissue for transplant when a Member is a donor except as provided in this Benefit Plan;
 - b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high dose chemotherapy to support transplant procedures;
 - c. the transplant of any non-human organ or tissue; or
 - d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.
9. Regardless of Medical Necessity services, Surgery, supplies, treatment or expenses related to:
- a. weight reduction programs;
 - b. removal of excess fat or skin, regardless of Medical Necessity, or services at a health spa or similar facility; or
 - c. [obesity or morbid obesity, regardless of Medical Necessity.]
FOR GROUPS WITH COVERAGE FOR MORBID OBESITY:
 [Services, Surgery, supplies or treatment for obesity or morbid obesity. However, Benefits will be provided for Surgery and services related to the Surgery for morbid obesity which is defined as a body mass index (BMI) greater than forty (40) or a BMI greater than thirty-five (35) with co-morbidities of clinically significant coronary artery disease, adult onset diabetes mellitus, hypertension (uncontrolled blood pressure greater than one hundred-fifty (150) systolic or ninety (90) diastolic) or major joint disease, which is attributable to the obesity.
 Other services and/ or supplies for obesity and morbid obesity are not covered.]
10. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products as described in this Benefit Plan.
11. Services or supplies for the treatment of eating disorders, unless otherwise required by law.
12. Pre-Existing exclusions are applicable as previously defined.

Groups with drug coverage through Blue Cross:

- [13. Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered in the Schedule of Benefits:
- a. lifestyle-enhancing drugs including but not limited to medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), hair loss or restoration (e.g., Propecia®, Rogaine®), effects of aging on the skin, medications for weight loss (e.g., Meridia®, Xenical®), or medications used to enhance athletic performance;
 - b. any medication not proven effective in general medical practice;
 - c. Investigational drugs and drugs used other than for the FDA approved indication, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals and all Medically Necessary services associated with the administration of the drug;
 - d. fertility drugs;
 - e. minerals and vitamins, except for vitamins requiring a prescription for dispensation;
 - f. nutritional or dietary supplements, or herbal supplements and treatments;
 - g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, or Prescription Drugs for which there is an OTC equivalent available.
 - h. contraceptive drugs;
 - i. contraceptive devices that do not result in permanent sterilization;
 - j. refills in excess of the number specified by the Physician or the dispensing limitation described in this Benefit Plan, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;
 - k. any drugs used for smoking cessation except Zyban;
 - l. compounded drugs that exhibit any of the following characteristics: 1) are similar to a commercially available product; 2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval; 3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically); 4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or 5) compounded prescriptions whose only ingredients do not require a prescription;
 - m. drugs for non-Covered orthodontic care, dental implants, and periodontal disease (e.g., Periostat®);
 - n. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;
 - o. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;
 - p. Prescription Drugs related to a non-Covered Service;
 - q. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®);
 - r. Medication, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner;
 - s. growth hormone therapy, except for chronic renal insufficiency, AIDS wasting, and Turners Syndrome, unless an endocrinologist confirms growth hormone deficiency with abnormal provocative stimulation testing;
 - t. Prescription Drugs for and/or treatment of idiopathic short stature; or
 - u. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Member misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy.]

Groups without drug coverage through Blue Cross:

- [13. Prescription Drugs other than those administered during a Hospital 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 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 that do not result in permanent sterilization;
 - 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.]

14. Injectable drugs that can be self-administered are not covered when obtained from an infusion therapy provider, unless prescribed in conjunction with intravenous infusions provided by the infusion therapy provider.
15. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Member's Coinsurance and the Group's financial responsibility. The Group will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Member's Copayment, in which case, the Member must pay the Prescription Drug cost and sales tax.
16. Personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, personal fitness equipment, or alterations to a Member's home or vehicle.
17. Charges for telephone or e-mail Consultations between a Provider and a Member, failure to keep a scheduled visit, completion of a Claim form, or to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.
18. Palliative or cosmetic foot care; care of flat foot conditions; supportive devices for the foot, except when used in the treatment of diabetic foot disease; care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints related to the feet.
19. Any abortion other than to save the life of the mother.
20. Services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits.
21. Services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.
22. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.
23. Hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.
24. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
25. Services, supplies or treatment for cosmetic purposes, Cosmetic Surgery and any complications of Cosmetic Surgery, unless required for a Congenital Anomaly.
26. Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits.
27. Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition.
28. Medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.
29. Travel, whether or not recommended by a Physician, and/or Ambulance Services, except as specifically provided in this Benefit Plan.
30. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Benefit Plan for diabetes; diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.
31. Admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.
32. Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.
33. Services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Benefit Plan.
34. Hospital charges for a well newborn.

