



HMO POS

INDIVIDUAL POINT OF SERVICE CONTRACT



A subsidiary of Blue Cross and Blue Shield of Louisiana and an independent licensee of the Blue Cross and Blue Shield Association.

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Thank you for choosing us!

It is my pleasure to welcome you to your new plan. If you are renewing your plan, welcome back! We are honored you chose the Cross and Shield for your health insurance needs. Please read this booklet for important information about your plan and how it works. If you have questions, we are here to help. Simply call the number on your ID card and we'll do our best to assist you.

My best to you,

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

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



WOMEN'S HEALTH AND CANCER RIGHTS ACT ENROLLMENT NOTICE FOR ALL COVERED MEMBERS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving benefits in connection with a mastectomy and elects breast reconstruction, coverage will be provided for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future;
- prostheses; and
- treatment of physical complications of all stages of the mastectomy, including lymphedema.

Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. You are eligible for these screenings if You:

- were previously diagnosed with breast cancer;
- completed treatment for breast cancer;
- underwent bilateral mastectomy; and
- were subsequently determined to be clear of cancer.

These benefits will be provided in a manner determined in consultation with the attending physician and the patient, and subject to the same deductibles, coinsurance, and copayments (if any) applicable to other medical and surgical benefits provided under this plan. Information on the plan's specific deductible, coinsurance, or copayment amounts is found in the Schedule of Benefits document that is issued with your health benefit booklet.

If you have questions about this notice or about the coverage described herein, please contact our Customer Service Department at the number listed on the back of your ID card.

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NOTICES

This Contract is not a Medicare supplement policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

If, upon examination of this Contract, the Subscriber is not satisfied, he or she may return it to the Company within ten (10) days after receipt and fees paid by the Subscriber will be refunded.

This Contract is guaranteed renewable at the Subscriber's option, provided premiums are paid in accordance with the Contract requirements and the Subscriber does not violate any of the provisions of the coverage under this Contract.

NOTICE: HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE NON-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT WWW.BCBSLA.COM OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON YOUR ID CARD.

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN US 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."

NOTICE: As part of long-term survivorship care, certain breast cancer survivors are eligible to receive annual preventive cancer screenings. You are eligible for these screenings if You:

- a. were previously diagnosed with breast cancer;
- b. completed treatment for breast cancer;
- c. underwent bilateral mastectomy; and
- d. were subsequently determined to be clear of cancer.

These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with You and Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any Copayment Amount, Deductible Amount and Coinsurance.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. Company does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Important information regarding this Contract will be sent to the mailing address provided for Members on the Application for Individual Coverage. **You are responsible for keeping HMO Louisiana, Inc. informed of any changes in Your address of record.**

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NOTICES

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

This Contract covers Prescription Drugs and uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Contract. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers.

Information about Your formulary is available to You in several ways. Most Members receive information from Us by accessing the pharmacy section of Our website, www.bcbsla.com/pharmacy.

You may also contact Us at the telephone number on Your ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your prescribing healthcare Provider will prescribe the drug for a particular medical condition or mental illness.

A closed formulary means that selected Brand-Name Drugs, Generic Drugs, and Specialty Drugs, when listed on the formulary, are covered. Drugs that are not listed on the closed formulary, also called non-formulary drugs, are not covered.

For Prescription Drugs that are not included in Our Prescription Drug Formulary, there is a drug review process. This process allows Your prescribing healthcare Provider to ask for a drug review from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the drug review request is not approved, You may file an internal or external drug review request to Us.

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

You have the right to continue the coverage of any Prescription Drug that was approved or covered by Us for a medical condition or mental illness, at the contracted Benefit level until the renewal of Your current insurance coverage regardless of whether the drug has been removed from Your formulary. Your prescribing healthcare Provider may prescribe a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is covered under the health plan and is medically appropriate for You.

**INDIVIDUAL
HMO POINT OF SERVICE CONTRACT
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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

HMO Louisiana, Inc. issues this health Contract to the Subscriber. A copy of this Contract provided to Subscribers serves as the Subscriber's certificate of coverage. As of the Contract Date or Amended Contract Date shown on the Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers and their enrolled Dependents. This Contract replaces any others previously issued to the Subscriber, as of the Amended Contract Date. This Contract describes Member Benefits, as well as Member rights and responsibilities under the Plan. We encourage You, the Member, to read this Contract carefully.

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

Except for necessary technical terms, We use common words to describe the Benefits provided under this Contract. "We," "Us" and "Our" means **HMO Louisiana, Inc.** (HMOLA). "You," "Your," and "Yourself" means the Subscriber and/or enrolled Dependent. Capitalized words are defined terms in Article II - "Definitions." A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

Please be aware that Your Physician does not have a copy of Your Contract, and is not responsible for knowing or communicating Your Benefits to You.

FACTS ABOUT THIS HMO POINT OF SERVICE CONTRACT

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

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

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

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

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

OUR HMOLA PROVIDER NETWORK

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

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

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

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

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

We pay a lower level of Benefits when a Member uses a Provider outside the HMOLA Network. Benefits may also be based on a lower Allowable Charge and/or the application of a penalty. The Member will usually pay Deductible and Coinsurance instead of a Copayment. Receiving care from a Non-Network Provider will result in higher Out-of-Pocket costs to the Member. Because Non-Network Providers are able to balance bill Members up to their full billed charge, Out-of-Pocket costs could be significant. These amounts do not apply to the Out-of-Pocket Maximum. We recommend that You ask the Non-Network Physician or healthcare professional about their billed charges before You receive care. You should review the sample illustration below in the section titled "Sample Illustration of Member Costs When Using a Non-Participating Hospital" prior to obtaining care outside the Network.

DAVIS VISION NETWORK

Davis Vision, Inc. (hereinafter, "Davis Vision") is the Company's network and Claims administrator for the Vision Care Benefit provided, and manages the Davis Vision Network, handles and pays Claims, and provides customer services to the Members eligible to receive this Benefit.

The Davis Vision Network consists of a select group of Providers who have contracted with Davis Vision to render services to Members for minimal out-of-pocket costs. **All other Providers are considered Non-Participating.**

In order to receive the full Benefit under this section, the Member should verify that a Provider is a Davis Vision Network Participating Provider before any service is rendered. To locate a Participating Provider and verify their continued participation in the Davis Vision Network, or to ask any questions related to Benefits or Claims, please visit the website at www.davisvision.com or contact a customer service representative at 1-800-247-9368.

SELECTING A PRIMARY CARE PHYSICIAN (PCP) FOR PLANS WITH AN OFFICE VISIT COPAYMENT

This coverage requires You to designate a Primary Care Physician. You have the right to designate any Primary Care Physician who participates in your Network and who is available to accept You or Your family members. Until You make this designation, We designate one for You. For children, You may designate a pediatrician as the Primary Care Physician. For women, You may designate an obstetrician/gynecologist (OB/GYN) as the Primary Care Physician. For information on how to select a Primary Care Physician, and for a list of the Primary Care Physicians in Your Network, visit www.bcbsla.com or call the Customer Service phone number on Your ID card.

You do not need prior authorization from Us or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a healthcare professional in Your Network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services. For a list of Network healthcare professionals who specialize in obstetrics or gynecology, visit www.bcbsla.com or call the Customer Service phone number on Your ID card.

USING A PRIMARY CARE PHYSICIAN (PCP)

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

Members pay the lowest Physician Copayment when obtaining care from a PCP. PCPs are family practitioners, general practitioners, internists, geriatricians and pediatricians. Each member of the family may use a different PCP. PCPs will coordinate healthcare needs from consultation to hospitalization, will direct a Member to an appropriate Provider when necessary, and will assist in obtaining any required Authorizations.

The Physician Office Copayment may be reduced or waived when services are rendered by a Provider participating in the Quality Blue Primary Care Program (QBPC). QBPC Providers include family practitioners, general practitioners, internists, nurse practitioners, and physician assistants.

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

AUTHORIZATIONS

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

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

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

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

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

HOW WE DETERMINE WHAT WE PAY FOR THE MEMBER'S COVERED SERVICES

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

What We pay When a Member uses Network Providers

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

What We pay When a Member uses Participating Providers

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

The Member has the right to file an Appeal with Us for consideration of a higher level of Benefits if You received Covered Services from a Participating Provider who was the only Provider available to deliver the Covered Service within a 75-mile radius of the Member's home. To file an Appeal, the Member must follow the Appeal procedures in this Contract.

What We pay When a Member uses Non-Participating Providers

Non-Participating Providers do not have a contract for the HMOLA Network, with Blue Cross and Blue Shield of Louisiana, or any another Blue Cross and Blue Shield plan. These Providers are not in Our Networks. We have no fee arrangements with them.

We establish an Allowable Charge for Covered Services provided by Non-Participating Providers. The Allowable Charge will be the lesser of the following:

- (1) An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;
- (2) an amount We establish as the Allowable Charge; or
- (3) the Provider's billed charge. You will receive a lower level of Benefit because You did not go to a Network Provider.

You may pay significant costs when using Non-Participating Providers. This is because the amounts that some Providers charge for Covered Services may be higher than the established Allowable Charge. Also, HMOLA Network Providers and Participating Providers waive the difference between the actual billed charge for Covered Services and the Allowable Charge, while Non-Participating Providers will not.

You have the right to file an Appeal with Us for consideration of a higher level of Benefits if You received Covered Services from a Non-Participating Provider who was the only Provider available to deliver the Covered Service within a 75-mile radius of Your home. To file an Appeal, follow the Appeal procedures in this Contract.

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

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

Example: A Member has this Point of Service plan with a \$150 Hospital Copayment. The Non-Network Benefits are 60% - 40% Coinsurance with a Deductible. Assume the Member goes to the Hospital, has previously met his Deductible, and has obtained the necessary Authorization prior to receiving a non-emergency service. The Provider's billed charge for the Covered Service is \$12,000. We negotiated an Allowable Charge of \$2,500 with HMOLA Network Providers to render this service. The Allowable Charge of Participating Providers is \$3,000 to render this service. There is no negotiated rate with the Non-Participating Provider Hospital.

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

DEPENDENT OUT-OF-AREA BENEFITS

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

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

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

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

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

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

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

WHEN A MEMBER PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with Us or with Our pharmacy Benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base Our payment for the Member's covered Prescription Drugs.

When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our pharmacy Benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense, the Allowable Charge is the negotiated amount that most Participating Pharmacies have agreed to accept as payment for drugs dispensed.

To obtain contact information for “Participating Pharmacies”, the Member should contact Our customer service department or Our Pharmacy Benefit Manager at the telephone number on His ID card.

MEMBER INCENTIVES AND VALUE-ADDED SERVICES

Sometimes We may offer Members coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. We may offer Members discounts or financial incentives to use certain Providers for selected Covered Services. We may also offer Members the opportunity to enroll in health and non-health related programs, as value-added services, to enhance the Member’s experience with Us or his Providers. These incentives and value-added services are not Benefits and do not alter or affect Member Benefits. They may be offered by Us, affiliated companies, and selected vendors. Members are always free to reject the opportunities for incentives and value-added services. We reserve the right to add or remove any and all coupons, discounts, incentives, programs, and value-added services at any time without notice to Members.

HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

We offer Members a wide range of health management and wellness tools and resources. Members can use these tools to manage their personal accounts, see claims history, create health records and access a host of online wellness interactive tools. Members also have access to a comprehensive wellness program that includes a personal health assessment and customized health report to assess health risks based on his history and habits. Exclusive discounts are also available to Members 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

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

IDENTITY PROTECTION SERVICES

HMO Louisiana, Inc. is committed to identity protection for its covered Members. This includes protecting the safety and security of Members’ information. To support the Company’s efforts, HMO Louisiana, Inc. offers optional Identity Protection Services. If Identity Protection Services are elected, the services will include the following:

1. Credit monitoring which monitors activity that may affect credit.
2. Fraud detection which identifies potentially fraudulent use of identity or credit.
3. Fraud resolution support that assists Members in addressing issues that arise in relation to credit monitoring and fraud detection.

A Member ceases to be eligible for these services if health coverage is terminated during the Plan year. In this event, Identity Protection Services will terminate at the end of the Plan year.

Information about Identity Protection Services can be found at www.bcbsla.com or by calling the customer service telephone number on the back of Your identification (ID) card.

ARTICLE II.

DEFINITION

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

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

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

- A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or investigational;
- B. the Member's eligibility to participate in the Contract;
- 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 Us to render Covered Services.

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

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

Allowable Charge –

- A. For Network Providers – The lesser of the billed charge or the amount We establish or negotiate as the maximum amount allowed for services from these Providers covered under this Contract.
- B. For Non-Network Providers – The lesser of:
 - 1. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;
 - 2. an amount We establish as the Allowable Charge; or
 - 3. the Provider's billed charge.

Alternative Benefits - Benefits for services not routinely covered under this Contract but which may be provided by agreement through Case Management.

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 Member or authorized representative to change an Adverse Determination made by the Company.

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.

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

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.

Beneficiary - A person designated by a participant, or by the terms of a health insurance Contract, who is or may become entitled to a Benefit under the plan.

Benefits - Coverage for healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies provided under this Contract. We base the payment for Benefits on the Allowable Charge for Covered Services.

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

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

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

Cardiac Rehabilitation - A structured program that provides coordinated, multi-faceted interventions including supervised exercise training, education, counseling and other secondary prevention interventions. It is designed to speed recovery from acute cardiovascular events such as myocardial infarction, myocardial revascularization, or hospitalization for heart failure and to improve functional and psychosocial capabilities.

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

Cellular Immunotherapy - A treatment involving the administration of a patient's own (autologous) or donor (allogeneic) anti-tumor lymphocytes following a lymphodepleting preparative regimen.

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 such as mechanical traction and mechanical massage, and other rehabilitative measures for the purpose of correcting interference with normal nerve transmission and expression.

Claim - A Claim is written or electronic proof, in a form acceptable to Us, of charges for Covered Services that have been incurred by You during the time period You were insured under this Contract. 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.

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

Coinsurance - The sharing of Allowable charges for Covered Services. The sharing is expressed as a pair of percentages, a Company percentage that We pay, and a Member percentage that You pay. Once the Member has met any applicable Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. Our percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Company – HMO Louisiana, Inc.

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

Complication(s) - A medical condition, arising from an adverse event or consequence, which requires services, treatment or therapy and which is determined by BCBSLA, based on substantial medical literature and experience, to be a direct and consequential result of another medical condition, disease, service or treatment. Solely as an example, a pulmonary embolism after Surgery would be a Complication of the Surgery.

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

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

Congenital Anomaly - A condition existing at or from birth, which is a deviation from the common form or norm. Only deviations that impact bodily functions are covered. Examples of Congenital Anomalies that do not impact bodily function and are not covered include, but are not limited to: protruding ears, birthmarks, webbed fingers and toes, and asymmetrical breasts. Cleft Lip and Cleft Palate are covered Congenital Anomalies; other conditions relating to teeth or structures supporting the teeth are not covered. We will determine which conditions are covered as Congenital Anomalies.

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

Contract - This agreement, including the Application for Coverage, the Schedule of Benefits and amendments/endorsements to this agreement, if any, entitling the Subscriber and covered Dependents to Benefits.

Contract Date - The date upon which We issued this Contract to You.

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 Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider.

Cosmetic Surgery - Any operative procedure, treatment or service, or any portion of an operative procedure, treatment or service performed primarily to improve physical appearance. 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 disorder, or covered Surgery has altered.

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

Creditable Coverage - Prior coverage under any individual or Group health plan including, but not limited to, Medicare, Medicaid, government plan, church plans, COBRA and military plans. 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 regulation under which Benefits for medical care are secondary or incidental to the insurance Benefits).

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

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

Deductible Amounts

A. Individual Deductible Amount –

1. The dollar amount, as shown on the Schedule of Benefits, of charges for Covered Services that a Member must pay within a Benefit Period before Benefits are provided. A separate Deductible Amount may apply to certain Covered Services if shown as applicable in on the Schedule of Benefits.
2. Network and Non-Network Benefit categories each carry a separate Individual Deductible Amount as shown on the Schedule of Benefits.

B. Family Deductible Amount – The dollar amount shown on the Schedule of Benefits for each category of Benefits to which a Deductible applies. Once a family has met its Family Deductible, this Contract starts paying Benefits for all members of the family, regardless of whether each individual has met his Individual Deductible Amount. Family Deductibles may apply to other types of Deductibles described in this Contract.

C. Prescription Drug Deductible Amount – The dollar amount, if shown on the Schedule of Benefits, which each Member must pay within a Benefit Period prior to paying a Prescription Drug Copayment or Coinsurance percentage. The Prescription Drug Deductible Amount does not accrue to the Individual Deductible Amount or the Family Deductible Amount.

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

- A. represents himself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws or associated

parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;

- B. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- C. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

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

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

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

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

Effective Date - The date when Your coverage begins under this Contract as determined by the Schedule of Eligibility. Benefits will begin at 12:01 AM on this date.

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

Eligible Person - A person entitled to apply to be a Subscriber 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 healthcare service provided to evaluate and/or treat an Emergency Medical Condition requiring immediate unscheduled medical care.

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

Expedited External Appeal - A request for immediate review, by an Independent Review Organization (IRO), of an initial Adverse Determination, which involves any of the following:

- A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function, or a decision not to Authorize continued services for Members currently in the Emergency room, under observation, or receiving Inpatient care.

B. A denial of coverage based on a determination the recommended or requested healthcare service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Member's health, including severe pain, potential loss of life, limb or major bodily function.

External Appeal – A request for review by an Independent Review Organization (IRO), to change an initial Adverse Determination made by the Company or to change a final Adverse Determination rendered on Appeal. External Appeal is available upon request by the Member or authorized representative for Adverse Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission.

Gene Therapy – A treatment involving the administration of genetic material to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use.

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

Gestational Carrier – A woman, not covered on the Plan, who agrees to engage in a process by which she attempts to carry and give birth to a child born as the result of an in utero transfer of a human embryo to which she makes no genetic contribution

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

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

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

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

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

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

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

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

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

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

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

- A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the United States 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.

Life-Threatening Illness – A severe, serious, or acute condition for which death is probable.

Low-Tech Imaging – Imaging services which include, but are not limited to x-rays, machine tests, diagnostic imaging and radiation therapy. If an image is defined as a High-Tech Image, then it is not a Low-Tech Image.

Medically Necessary (Medical Necessity) - Healthcare 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.

Member - A Subscriber or an enrolled Dependent.

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 Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic Mental Disorders, to be determined by the Company. The definition of Mental Disorder shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Multi-Source Brand Drug - A Brand-Name Drug for which a Generic Drug equivalent is available.

Network Benefits - Benefits for care received from a Network Provider.

Network Provider - A Provider that has signed an agreement with Us to participate as a Member of the HMO Louisiana, Inc. Provider Network. This Provider may also be referred to as an HMOLA or Network Provider.

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

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

Non-Network Provider - A Provider who is not a Member of the HMO Louisiana, Inc. Network. Participating Providers and Non-Participating Providers are Non-Network Providers as they are not contracted with the HMOLA Provider Network.

Non-Preferred Brand/Generic Drug – Prescription Drugs that are Brand-Name Drugs or Generic Drugs that may have a therapeutic alternative called a Value Drug or a Preferred Brand Drug.

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 each Policy Year, specified in the Schedule of Benefits, during which a Subscriber and/or their eligible Dependents may enroll for Benefits under this Contract.

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

Out-of-Pocket Amount - The maximum amount of unreimbursable expenses that a Member must pay for Covered Services in one Benefit Period.

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

Over-Age Dependent – A Dependent Child (or Grandchild) who is age 26 or older, reliant on Subscriber for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age 26. Coverage of the Over-Age Dependent may continue after age 26 for the duration of incapacity if, prior to or within thirty-one (31) days of the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending Physician is submitted to Company. Company may require additional or periodic medical documentation regarding the Dependent Child's intellectual or physical disability as often as it deems necessary, but not more frequently than once per year after the two year period following the child's 26th birthday. Company may terminate coverage of the Over-Age Dependent if Company determines the Dependent Child is no longer reliant on Subscriber for support or is no longer intellectually or physically disabled to the extent he is incapable of sustaining employment.

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.

Pharmacy Benefit Manager (PBM) – A third party administrator of Prescription Drug programs.

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.

Policy Year - The twelve (12)-month period of time beginning with the Effective Date of this Contract or the anniversary of this date, and ending on the day before the next anniversary of the Effective Date of this Contract.

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

Preferred Brand Drug – A commonly prescribed Brand-Name Prescription Drug that has been selected based on its clinical effectiveness and safety.

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

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

Prescription Drug Deductible Amount - The amount, if shown in the Schedule of Benefits, which must be met by a Member or a family within a Benefit Period prior to any applicable Prescription Drug Copayment or Coinsurance percentage.

Prescription Drug Formulary - A list of specific Prescription Drugs that are covered under this insurance policy.

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

Primary Care Physician (PCP) - A Physician who is a family practitioner, general practitioner, internist, geriatrician, or pediatrician. When performing primary care services, a nurse practitioner and a physician assistant may be treated as a PCP.

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

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

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

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

A. HMOLA Provider - A Provider that has a signed contract with Us to participate in Our Provider Network. This Provider is also referred to as an HMOLA Provider, Network Provider, or Network Provider.

- B. Participating Provider - A Provider that does not have a signed contract with HMOLA, but has a signed contract with Our parent company, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan to participate in its Provider Networks.
- C. Non-Participating Provider - A Provider that does not have a signed contract with HMOLA, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.

Quality Blue Primary Care (QBPC) Provider – A Provider who is a family practitioner, general practitioner, internist, geriatrician, nurse practitioner or physician assistant, and who has signed an agreement to participate in the Quality Blue Primary Care program.

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

Repatriation - The act of returning to the country of birth, citizenship or origin.

Rescission - Cancellation or discontinuance of coverage that has retroactive effect.

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

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

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 or unit;
- B. Full-time supervision by at least one Physician or Registered Nurse;
- C. Twenty-four (24) hour nursing service by Registered Nurses or Licensed Practical Nurses; and
- D. Utilization review plans for all patients.

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

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

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.

Spouse – The Subscriber’s legal Spouse.

Subscriber - An Eligible Person who has satisfied the specifications of this Contract’s Schedule of Eligibility and has enrolled for coverage, and to whom We have issued a Contract.

Surgery –

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

Telehealth Services - A mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from healthcare Providers approved by Us to render Telehealth Services. Telehealth Services give Providers the ability to render services when Provider and patient are in different locations. Unless otherwise provided in the Telehealth Services Benefit, interaction between Provider and patient must generally be held simultaneously by two-way video and audio transmission.

- A. Asynchronous Telehealth Services – the transmission of a patient’s pre-recorded medical information from an originating site to the Provider at a distant site without the patient being present.
- B. Synchronous Telehealth Services – the interaction between patient and Provider in different locations in real time, by means of two-way video and audio transmission, usually through an established patient portal.

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

Temporomandibular/Craniomandibular Joint (TMJ) 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, stomachaches and nausea. Urgent Care may be accessed from an Urgent Care Center that is in Our Network if You require non-Emergency medical care or You require Urgent Care after Your Physician’s normal business hours.

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

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

Value Drugs – Low-cost Generic Drugs and some low-cost Brand-Name Drugs.

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 CONTRACT, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS.

A. Eligibility

1. Subscriber. A Subscriber is a person who resides in the HMO Louisiana, Inc. Service Area and has signed the Application for Individual Health Coverage, or a person on whose behalf an application has been signed by the appropriate legal representative, and which has been accepted by Us. The Subscriber must be a resident of this state.

2. Dependent. To be eligible to apply as a Dependent, an individual must meet the following criteria at the time of application. 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 Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Contract:
 - a. Spouse

 - b. CHILDREN: A child under age twenty-six (26) who is one of the following:
 - (1) born of the Subscriber; or
 - (2) legally placed for adoption with the Subscriber; or
 - (3) legally adopted by the Subscriber; or
 - (4) a child for whom the Subscriber or his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his Spouse is a court appointed tutor/tutrix; or
 - (5) a child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or
 - (6) a stepchild of the Subscriber; or
 - (7) a grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or
 - (8) the Subscriber's child, or grandchild who is in the legal custody of and residing with the Subscriber, who is covered on the Plan before turning age twenty-six (26) and is able to remain covered on the Plan once turning age 26 because he meets the definition and requirements of an Over-Age Dependent.

B. Enrollment/Effective Date of Coverage

1. An individual may apply for coverage under this Contract and may include any eligible Dependents in such application during the annual Open Enrollment period. Eligible Dependents may also apply for coverage during the annual Open Enrollment period. No one will be allowed to apply or enroll outside of the Open Enrollment period, unless that individual qualifies for special enrollment, as specified in this Contract.

2. No person for whom coverage is sought will be covered under this Contract unless the application for coverage has been approved by the Company and such approval has been evidenced by the issuance of an identification card or other written notice of approval.
Payment of premiums to the Company for any person for whom coverage is sought will not effectuate coverage unless and until the Company's ID card or other written approval has been issued, and in the absence of such issuance, the Company's liability will be limited to refund of the amount of premiums paid.

3. The following classes of coverage are available under this Contract:
 - a. Subscriber Only coverage means coverage for the Subscriber only.
 - b. Subscriber and Spouse coverage means coverage for the Subscriber and his Spouse.
 - c. Subscriber and Family coverage means coverage for the Subscriber, his Spouse, and one or more Dependent children.
 - d. Subscriber and Child (or Children) coverage means coverage for the Subscriber and one or more Dependent children.
4. When an application has been approved and any premiums for coverage have been paid in advance as required by this Contract, coverage will commence on the date We assign as Your Effective Date. No Claims will be paid for dates of service prior to Your Effective Date.

5. Special Enrollment Due to Acquiring New Dependents

This Contract shall provide for a special enrollment period during which You may apply to add new Dependents. The Subscriber must complete and submit a health questionnaire to Us within the special enrollment period. To add a Newly Born Infant (natural born or adopted), a Change of Status Card must be completed, as described below. If accepted, the new Dependent will be assigned the next available Effective Date. Premiums may be adjusted for the additional coverage if adding the new Dependent changes the class of coverage under the Contract.

- a. A person becomes a new Dependent of the Subscriber through marriage, birth, adoption, or placement for adoption.
- b. There is a one month period of automatic coverage for Newly Born Infants (natural born or adopted), as described below. Any period of automatic coverage for Newly Born Infants (natural or adopted) runs concurrently with the special enrollment period for adding these infants to this Contract.
- c. The special enrollment period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage or birth.
- d. For Adopted Children other than Newly Born Adopted Infants, the one month special enrollment period shall begin on:
 - (1) For a legally adopted child, the date of the first court decree of adoption.
 - (2) For a child legally placed for adoption following a voluntary act of surrender of the child to the custody of the Subscriber (or his legal representative) that becomes irrevocable, the date of placement into the Subscriber's home.
 - (3) For a child placed in the custody of a Subscriber, the date the court order awarding custody is legally effective.
- e. If the completed health questionnaire or Change of Status Card is not received within the special enrollment period, the request will be denied and any period of automatic coverage will end. Any later request to add coverage for such new Dependent must be made at Open Enrollment.

6. Newly Born Infants (Newborns)

- a. If a child is born to a Subscriber holding Subscriber Only coverage or Subscriber and Spouse coverage, the following will apply:
 - (1) Such child will be covered automatically for one month from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his home, whichever is longer. This is the automatic coverage period. Automatic coverage for the child will be provided if You notify Us of the birth of the child. Coverage for the child will continue in effect thereafter, without evidence of insurability, only upon Our receipt of a completed Change of Status Card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the child are paid when billed.
 - (2) If the completed Change of Status Card is not received within this period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the child must be made at Open Enrollment.
- b. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage) the Effective Date for coverage for such child will be the date of birth. You must notify Us within one hundred and eighty (180) days of the birth to update Our records.

7. Newly Born Adopted Infants

- a. If within one month of the birth of a child, the child is either: legally placed into Subscriber's home for adoption following a voluntary act of surrender to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to, a Subscriber holding Subscriber Only coverage or Subscriber and Spouse coverage, the following will apply:
 - (1) The Newly Born Infant will be covered automatically for one month. The one month period begins to run from the date of legal placement into the Subscriber's home or from the custody order, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit, whichever is longer. Coverage for the child will continue in effect thereafter, without evidence of insurability, only upon Our receipt of a completed Change of Status card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the child are paid when billed.
 - (2) If the completed Change of Status Card is not received within this period, coverage for the child will terminate upon the expiration of the period of automatic coverage. Any later request to add coverage for the Newly Born Infant must be made at Open Enrollment.
- b. If within one month of the birth of a child, the Newly Born Infant is either: legally placed into the Subscriber's home for adoption following a voluntary act of surrender, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), the Effective Date for coverage for such adopted newborn child will be the date of placement into Subscriber's home or the date of the custody order. You must notify Us within one hundred eighty (180) days of the date of placement in the home or of the custody order to update Our records.

ARTICLE IV.

BENEFITS

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

A. Benefit Categories

1. The HMO Louisiana, Inc. Point of Service Contract includes the following categories of Benefits:
 - a. Network Benefits - Benefits for Covered Services received from a Network Provider. When a Member receives care from a Network Provider, he will receive the highest level of Benefits on this plan.
 - b. Non-Network Benefits - Benefits received from a Provider who is not contracted with HMO Louisiana, Inc. When a Member receives care from a Non-Network Provider, he will receive a lower level of Benefits on this plan.
 - c. Dependent Out-of-Area Benefits - Benefits for Covered Services provided to the Subscriber's Dependents who are regularly located outside of the Subscriber's defined Service Area and who enroll for Dependent Out-of-Area Benefits.

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

Additionally, Network Benefits paid by Us to an HMO Network Provider may be reduced for the Provider's failure to obtain prior Authorization from Us when required to do so. Refer to the Authorization of Services and Supplies section of this Contract and the Schedule of Benefits for additional information.

2. Network Benefits

You must pay all Copayments, Deductible Amounts, and applicable Coinsurance percentages shown in the Schedule of Benefits for a specified Covered Service each time the Covered Service is rendered, subject to any limitations or maximum Benefits shown. These amounts are subject to change from time to time.

3. Non-Network and Dependent Out-of-Area Benefits

Subject to any Deductible Amounts shown in the Schedule of Benefits, and the maximum limitations and other terms and provisions of this Contract, We will provide Benefits in the Coinsurance percentages shown in the Schedule of Benefits toward Allowable Charges You incur for Covered Services during a Benefit Period. Our actual payment to a Participating Provider or payment to You satisfies Our obligation to provide Benefits under this Contract. Deductible Amounts, Copayments and Coinsurance percentages are subject to change from time to time.

Network and Dependent Out-of-Area Benefits have separate Deductibles, as shown in the Schedule of Benefits and do not accrue to each other.

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

Network and Dependent Out-of-Area Benefits have separate Out-of-Pocket Amounts, as shown in the Schedule of Benefits and do not accrue to each other.

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

(1) Coinsurance;

(2) Hospital Inpatient Copayment; and

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

b. The following do not accrue to the Out-of-Pocket Amount:

- (1) Deductible Amounts;
- (2) Copayments that the Member pays other than Inpatient Hospital Copayment, Ambulatory Surgical Facility and Outpatient Surgical Facility Copayments;
- (3) any charges in excess of the Allowable Charge;
- (4) any penalties the Member or Provider must pay; and
- (5) charges for non-Covered Services.

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

B. Deductible Carryover

The Allowable Charges incurred for Covered Services during the months of October, November and December which were applied toward the Benefit Period Deductible Amount, but did not satisfy the Benefit Period Deductible Amount, will be applied to Your 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 Prescription Drug Deductible Amount, Family Deductible Amount or any other type of Deductible described in this Contract.

C. Deductible Amount

We will apply Your 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 You, then when You receive Covered Services from another Provider, that Provider also collects Your Deductible Amount. This generally occurs when Your Claims have not been received and processed by Us. Our system will only show the Deductible Amount applied for Claims that have been processed. Therefore, You may need to pay toward the Deductible Amount until Your Claims are submitted and processed, showing that the Deductible Amount has been met. If You overpay Your Deductible Amount, You are entitled to receive a refund from the Provider in which the overpayment was made.

D. Copayment Services

The Member must pay a Copayment each time applicable Covered Services are rendered. The amount of the Copayment depends on the type of Network Provider rendering the service. Office visit Copayments, if applicable, will be at the Primary Care Physician or Specialist amount shown on the Schedule of Benefits.

The Physician office Copayment may be reduced or waived when services are rendered by a Provider participating in the Quality Blue Primary Care Program (QBPC).

1. Examples of Covered Services subject to Copayments:

- a. Office visits and consultations;
- b. Surgical procedures performed in the Physician office; and
- c. Diabetes education.

2. The following services are covered at 100% of the Allowable Charge when obtained in the office and performed by a Network Physician or other Provider who is subject to an office visit Copayment:

- a. Injections, allergy serums and vials of allergy medication;

- b. Allergy testing;
- c. Anesthesia;
- d. Chemotherapy;
- e. Radiation treatment;
- f. Low-Tech Imaging;
- g. Lab tests;
- h. Dialysis;
- i. Infusion therapy; and
- j. Medical and surgical supplies.

E. Accumulator Transfers

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

ARTICLE V.

HOSPITAL BENEFITS

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

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

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 Member 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.

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, charges for administering transfusions, 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.
8. Psychological testing when ordered by the attending Physician and performed by an employee of the Hospital.

C. Emergency Room (Facility Only)

The Member must pay an Emergency Room Copayment, Deductible Amount and/or Coinsurance, if shown on the Schedule of Benefits, for each visit the Member makes to a Hospital or Allied Health Facility for Emergency Medical Services.

The Emergency Room Copayment is waived if the visit results in an Inpatient Admission.

D. Pre-Admission Testing

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

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

Benefits for the following surgical and medical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. The Member must pay all Copayments, any applicable Deductible Amounts and Coinsurance percentages, and is subject to other limitations shown in the Schedule of Benefits.

A. Surgical Services

1. Surgery
 - a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits.

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

b. Secondary Procedure(s)

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

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 Us.
- (2) The Allowable Charge includes the rebundled procedure. We will provide Benefits according to the proper comprehensive procedure code for the rebundled procedure, as We determine.

e. Mutually Exclusive Procedure(s)

- (1) Mutually exclusive procedures are two (2) or more procedures that are usually not performed at the same operative session on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the Physician should be submitting only one (1) of the codes. Mutually exclusive procedures are two (2) or more procedures that by medical practice standards should not be performed on the same patient, on the same day of service, for which separate billings are made.
- (2) The Allowable Charge includes for all procedures performed at the same surgical setting. Procedure(s), which are not considered Medically Necessary, will not be covered.

3. Assistant Surgeon

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

4. Anesthesia

- a. General anesthesia services are covered when requested by the operating Physician and performed by a certified registered nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. Medical direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.
- b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless We determine otherwise.

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

5. Second Surgical Opinion

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

B. Inpatient Medical Services

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

1. Inpatient Medical Care Visits
2. Concurrent Care
3. Consultation (as defined in this Contract)

C. Outpatient Medical and Surgical Services

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

ARTICLE VII.

PRESCRIPTION DRUG BENEFITS

Prescription Drugs are covered as shown below.

- A. The Prescription Drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown in the Schedule of Benefits.
- B. Some pharmacies have contracted with Us or with Our pharmacy Benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is the negotiated amount and it is used to base Our payment for the Member's covered Prescription Drugs.

To obtain contact information for "Participating Pharmacies", the Member should contact Our customer service department or Our Pharmacy Benefit Manager at the telephone number on His ID card.

- C. The Member should present his or her ID card to the pharmacist when purchasing covered Prescription Drugs at a Participating Pharmacy. The Prescription Drug Deductible, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. If the Member has not met his Prescription Drug Deductible, the Participating Pharmacy may collect one hundred percent (100%) of the discounted costs of the drug at the point of sale. If the member has met his Prescription Drug Deductible, he will pay the Copayment or

Coinsurance percentage shown on the Schedule of Benefits. The Participating Pharmacy will electronically submit the claim for the Member.

D. Prescription Drug Formulary

This Contract covers Prescription Drugs and uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Contract. Within the prescription drug formulary, drugs are placed on different tiers which represent varying cost share amounts. In General, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers. For covered drugs that are listed on the formulary, Our Drug Utilization Management Program, more fully described in the section below, may apply.

Information about Your formulary is available to You in several ways. Most Members receive information from Us by accessing the pharmacy section of Our website, www.bcbsla.com/pharmacy, or request a copy by mail by calling Our pharmacy Benefit manager at the telephone number identified on Your ID card.

You may also contact Us at the telephone number on Your ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your prescribing healthcare Provider will prescribe the drug for a particular medical condition or mental illness.

A closed formulary means that selected Brand-Name Drugs, Generic Drugs, and Specialty Drugs, when listed on the formulary are covered. Drugs that are not listed on the closed formulary, also called non-formulary drugs, are not covered.

For Prescription Drugs that are not included in Our Prescription Drug Formulary, there is a drug review process. This process allows Your prescribing healthcare Provider to ask for a drug review from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the drug review request is not approved, You may file an internal or external drug review request to Us.

Closed Formulary – (Four Tier)

1. The Prescription Drug Deductible, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Member may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Member may be required to pay a different Copayment or Coinsurance depending on whether the Member's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.
2. The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. You may call customer service or go to www.bcbsla.com/pharmacy to identify the tier classification of Your Prescription Drug.
3. If a formulary exception request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary at Tier 3 if it is a non-Specialty Drug and at Tier 4 if it is a Specialty Drug.
 - a. Tier 1 – Value Drugs
 - b. Tier 2 – Preferred Brand Drugs
 - c. Tier 3 – Non-Preferred Brand/Generic Drugs
 - d. Tier 4 – Specialty Drugs

E. Drug Utilization Management Program

Our Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Member safety, appropriate and cost effective use of medications, and monitor healthcare quality. Examples of these programs include:

1. Prior Authorization – As part of Our Drug Utilization Management program, Members and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on Our website at www.bcbsla.com/pharmacy or by calling the customer service telephone number on the Member's ID Card. If the Prescription Drug requires prior Authorization, the Member's Physician must call the medical Authorization telephone number on the Member's ID Card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.
 2. Safety checks – Before the Member's prescription is filled, Our pharmacy Benefit manager or We perform quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g. refill prior to seventy-five percent (75%) day supply used).
 3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by Us are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity Per Dispensing Limits/Allowances are based on the following: (a) the manufacturer's recommended dosage and duration of therapy; (b) common usage for episodic or intermittent treatment; (c) FDA-approved recommendations and/or clinical studies; or (d) as determined by Us.
 4. Step Therapy – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, We may require the Member to first try one or more Prescription Drugs to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, We may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then We will cover a prescription written for Drug B. However, if Your Physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.
- F. Necessary insulin syringes and test strips are covered under the Prescription Drug Benefit. When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our pharmacy Benefit manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that it dispenses, the Allowable Charge is the negotiated amount that Participating Pharmacies have agreed to accept for drugs dispensed.
- G. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Member should submit Claims on Our Prescription Drug claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Member should contact Us or Our pharmacy Benefit manager at the telephone number indicated on the Member's ID card.
- H. As part of Our administration of Prescription Drug Benefits, We may disclose information about the Member's Prescription Drug utilization, including the names of Your prescribing Physicians, to any treating Physicians or dispensing pharmacies.
- I. Any savings or rebates We receive on the cost of drugs purchased under this Contract from drug manufacturers are used to stabilize rates. Members may be subject to an excess consumer cost burden when Covered Prescription Drugs are purchased under this Benefit Plan. (La. R.S. 22:976.)

ARTICLE VIII.

PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to You. The Deductible Amount does not apply to Covered Services for Preventive or Wellness Care, if services are rendered by a Network Provider.

If You receive Covered Services for Preventive or Wellness Care from a Network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge, after applicable Copayment. If a Member received Covered Services for Preventive or Wellness Care from a Non-Network Provider, Benefits will be subject to the Coinsurance percentage shown in the Schedule of Benefits.

A. Well Woman Examinations

1. Routine annual visits to a Network obstetrician/gynecologist or other Physician. Additional visits recommended by the Member's obstetrician/gynecologist or other Physician may be subject to the Deductible Amount, Copayment or Coinsurance percentage shown in the Schedule of Benefits, if not a preventive service.
2. One (1) routine Pap smear per Benefit Period.
3. Mammography Examinations
 - a. Film mammograms
 - b. 3-D mammograms (digital breast tomosynthesis)

B. Physical Examinations and Testing

1. Routine Wellness Physical Exam - 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, and nuclear cardiology are not covered under this Preventive and Wellness Care Benefit. These High-Tech Imaging services may be covered under standard contract 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 Your Physician.

D. Colorectal Cancer Screenings

Benefits are available for routine colorectal cancer screenings provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational. If the following Covered Services for colorectal cancer screening are rendered by a Network Provider, Benefits will be paid at one hundred percent (100%) of the Allowable Charge.

1. FIT (Fecal Immunochemical Test for blood) fecal occult blood test
2. One (1) Cologuard (FIT-fecal) DNA Testing (1 every 3 years for ages 50-75)
3. One (1) Computed Tomographic (CT) Colonography (1 every 5 years for ages 50-75)
4. One (1) Flexible Sigmoidoscopy (1 every 5 years for ages 50 -75)
5. One (1) Colonoscopy (1 every 10 years for ages 50-75)

E. Other Wellness Services

1. 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 his Physician if the Member is over forty (40) years of age. A second visit shall be permitted if recommended by Your Physician for follow-up treatment within sixty (60) days after the visit, if related to a condition diagnosed or treated during the visits.
2. Intensive behavioral counseling for an obesity diagnosis is covered for Members ages three (3) through eighteen (18). Benefits are limited to fifty-two (52) visits for children prior to age 19 at no cost to the Member when services are rendered by a Network Provider. Visits exceeding fifty-two (52) from ages three (3) through eighteen (18) will be paid subject to contract benefits. Adults are limited to twenty-four (24) intensive behavioral counseling visits for obesity per Benefit Period at no cost to Member when using a Network Provider. Visits exceeding twenty-four (24) will be paid subject to contract benefits.

WHAT A MEMBER PAYS FOR PREVENTIVE OR WELLNESS CARE BENEFITS			
Wellness Benefit	HMO NETWORK PROVIDERS	NON-NETWORK PROVIDERS	DEPENDENT OUT-OF-AREA
Well Woman Exams			
OB/GYN office visits	No Cost	Deductible & Coinsurance	No Cost
Routine Pap Smear	No Cost	Coinsurance	No Cost
Film Mammogram	No Cost	Coinsurance	No Cost
3-D Mammogram	No Cost	Coinsurance	No Cost
Physical Exams			
Routine Physical Exam (including related diagnostic tests)	No Cost	Deductible & Coinsurance	No Cost
Well Baby Care	Copayment	Deductible & Coinsurance	No Cost
Immunizations			
State-Mandated Immunizations	No Cost	Coinsurance	No Cost
All Other Recommended by Physician	No Cost	Coinsurance	No Cost
Colorectal Cancer Screenings			
FIT (Fecal Immunochemical Test for blood)	No Cost	Deductible & Coinsurance	No Cost
Flexible Sigmoidoscopy	No Cost	Deductible & Coinsurance	No Cost
Colonoscopy	No Cost	Deductible & Coinsurance	No Cost
Cologuard (FIT-fecal) DNA Testing	No Cost	Deductible & Coinsurance	No Cost
Computed Tomographic (CT) Colonography	No Cost	Deductible & Coinsurance	No Cost
Other Wellness Services			
PSA test	No Cost	Coinsurance	No Cost

F. Preventive or Wellness Care Services

The list of covered Preventive and Wellness Care services changes from time to time. To check the current list of covered services, you may view a copy of our Grandfathered Preventive Care Services brochure by visiting Our website at: www.bcbsla.com/preventive.

ARTICLE IX. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in the HMOLA Network, the United Concordia Dental Network (Advantage Plus) or Blue Cross and Blue Shield of Louisiana's dental network are considered Network Providers. Access these Networks online at www.bcbsla.com, or call the customer service telephone number on Your ID card for copies of the directories. Coverage is provided only for the following services or procedures:

- A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth;
- B. 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 that 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.);
- C. Excision of exostoses or tori of the jaws and hard palate;
- D. Incision and drainage of abscess and treatment of cellulitis;
- E. Incision of accessory sinuses, salivary glands, and salivary ducts;
- F. Anesthesia for the above services or procedures when rendered by an oral surgeon;
- G. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia;
- H. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when the 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; and
- I. Benefits are available for dental services not otherwise covered by this Contract, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To determine if the Member is eligible for these Benefits, please call Our Customer Service Unit at the telephone number on the Member's ID card, and ask to speak to a Case Manager.

ARTICLE X. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

OUR AUTHORIZATION IS REQUIRED FOR THE EVALUATION OF YOUR SUITABILITY FOR ALL SOLID ORGAN AND BONE MARROW TRANSPLANT PROCEDURES. FOR THE PURPOSES OF COVERAGE UNDER THIS CONTRACT, ALL AUTOLOGOUS PROCEDURES ARE CONSIDERED TRANSPLANTS.

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

A. Acquisition Expenses

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

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

B. Organ, Tissue and Bone Marrow Transplant Benefits

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or an HMO Louisiana, Inc. (HMOLA) Network facility, unless otherwise approved by Us in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To locate an approved transplant facility, Members should contact Our Customer Service Department at the number listed on their ID card.
2. The Organ, Tissue and Bone Marrow Transplant Benefits are shown in the Schedule of Benefits and are not covered under the Non-Network Benefit category. Benefits are provided for Network services and for Dependent Out-of-Area services.
3. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).
4. Benefits as specified in this section will be provided for treatment and care because of or directly related to the following transplant procedures:
 - a. Solid Human Organ Transplants of the:
 - (1) Liver;
 - (2) Heart;
 - (3) Lung;
 - (4) Kidney;
 - (5) Pancreas;
 - (6) Small bowel; and
 - (7) Other solid organ transplant procedures, which We determine, has become standard, effective practice and has 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.

b. 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 Care Management Article. These following tissue transplants are covered:

- (1) Blood transfusions;
- (2) Autologous parathyroid transplants;
- (3) Corneal transplants;
- (4) Bone and cartilage grafting;
- (5) Skin grafting;
- (6) Autologous islet cell transplants; and
- (7) Other tissue transplant procedures, which We determine, has become standard, effective practice and has 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.

c. Bone Marrow Transplants

- (1) Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.
- (2) Other bone marrow transplant procedures, which We determine, has become standard, effective practice and has 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 XI. PREGNANCY CARE AND NEWBORN CARE BENEFITS

Benefits for ectopic pregnancies and spontaneous abortions (miscarriages) are available under the Hospital Benefits and Medical and Surgical Benefits Articles of this Contract.

Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a patient covered as a Subscriber or Dependent wife of a Subscriber whose coverage is in effect at the time such services are furnished in connection with her pregnancy. An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn child **only if** the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal complications.

Pregnancy Care Benefits are as follows:

A. Surgical and Medical Services

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

B. Facility Services

Hospital services required in connection with pregnancy and Medically Necessary abortions as described above. 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.

Elective deliveries prior to the thirty-ninth (39th) week of gestation will be denied as not Medically Necessary unless medical records support Medical Necessity. Facility and other charges associated with an elective early delivery that is not Medically Necessary will also be denied.

C. Benefits

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

D. Newborn Care

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

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

ARTICLE XII.

REHABILITATIVE CARE BENEFITS

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

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

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

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 must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.
3. Prevention, wellness and education related services for Occupational Therapy shall not require a referral.

B. Physical Therapy

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.
2. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.
3. 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 Member's plan of care.
 - b. As part of a Home Health Care agency pursuant to the Member's plan of care.
 - c. To a patient in a nursing home pursuant to the Member's plan of care.
 - d. Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness.
 - e. To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

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

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.
2. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

ARTICLE XIII. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

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

A. Ambulance Service Benefits

1. Ground Ambulance Transport Services

a. Emergency Transport

Benefits for Ambulance Services are available for local transportation for Emergency Medical Conditions only as follows:

- (1) for Members, to or from the nearest Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care;
- (2) for a 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; or
- (3) for the Temporarily Medically Disabled Mother of an ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

b. Non-Emergency Transport

Benefits for Ambulance Services are available for local transportation of Members for medical conditions that do not present an emergency to obtain Medically Necessary Inpatient or Outpatient services when the Member is bed-confined or his condition is such that the use of any other method of transportation is contraindicated. Benefits for non-Emergency transport are only available for transport to or from the nearest facility or Hospital capable of providing the Medically Necessary services.

The Member must meet all of the following criteria for bed-confinement to qualify for non-Emergency transport:

- (1) unable to get up from bed without assistance; and
- (2) unable to ambulate; and

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

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

2. Ground Ambulance Without Transport

Benefits are available for ambulance response and treatment at the scene, without transporting the Member to a facility for further medical care.

3. Air Ambulance Transport Services

a. Emergency Transport

Benefits for air Ambulance Services are available for Members with an Emergency Medical Condition. For Emergency Medical Conditions, 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 Services to be covered.

Benefits for air Ambulance Services are also available for emergency transport when the Member is in a location that cannot be reached by ground ambulance.

The air Ambulance transport is to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care.

b. Non-Emergency Transport

If Authorized by Us before services are rendered, Benefits for non-Emergency air Ambulance Services are available for Members, to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care . Once Authorized, you should verify the Network participation status of the air Ambulance Service Provider in the state or area the pick-up is to occur, based on zip code. To locate a Network Provider in the state or area where you will be receiving services, please go to the Blue National Doctor & Hospital Finder at <http://provider.bcbs.com> or call 1-800-810-2583.

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. The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.
- c. No Benefits are available if transportation is provided for a Member's comfort or convenience.
- d. No Benefits are available when a Hospital transports Members between parts of its own campus or between facilities owned or affiliated with the same entity.

B. 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. However, Benefits provided will not exceed two thousand five hundred dollars (\$2,500.00) per Benefit Period. You will be responsible for charges in excess of the Benefit Period maximum, if any. Charges in excess of the Benefit Period maximum are non-covered services and do not accrue to Your Out-of-Pocket Amount.

C. Bone Mass Measurement

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

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

D. BRCA1 and BRCA2 Genetic Testing

Genetic testing of BRCA1 and BRCA2 genes will be covered to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force recommendations for testing.

Deductible, Coinsurance and/or Copayment Amounts are applicable.

E. Breast Reconstructive Surgical Services and Breast Cancer Long-Term Survivorship Care

1. Under the Women's Health and Cancer Rights Act, if you are receiving Benefits in connection with a mastectomy and elect breast reconstruction, You will also receive Benefits for the following Covered Services:
 - a. All stages of reconstruction of the breast on which the mastectomy has been performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future;
 - c. prostheses; and
 - d. treatment of physical complications of all stages of the mastectomy, including lymphedema.

These Covered Services shall be delivered in a manner determined in consultation with You and Your attending Physician, if applicable, and will be subject to any Deductible Amounts, Copayment and Coinsurance.

2. Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. You are eligible for these screenings if You:
 - a. were previously diagnosed with breast cancer;
 - b. completed treatment for breast cancer;
 - c. underwent bilateral mastectomy; and
 - d. were subsequently determined to be clear of cancer.

These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with You and Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any Copayment Amount, Deductible Amount and Coinsurance.

F. Cleft Lip and Cleft Palate Services

Covered Services include the following:

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 insure 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; and
9. Genetic assessment and counseling for patient and parents.

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

G. Clinical Trial Participation

1. Patient costs are covered when incurred for treatment provided in a clinical trial for cancer, as described in this paragraph. Coverage will be subject to any applicable Copayment, Deductible, and/or Coinsurance amounts shown in the Schedule of Benefits.
2. The following services are not covered:
 - a. non-healthcare services provided as part of the clinical trial;
 - b. costs for managing research data associated with the clinical trial;
 - c. Investigational drugs or devices; and/or
 - d. services, treatment or supplies not otherwise covered under this Contract.
3. Investigational treatments and associated protocol related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:
 - a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
 - b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
 - c. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
 - (1) One of the United States National Institutes of Health.
 - (2) A cooperative Group funded by one of the National Institutes of Health.
 - (3) The FDA, in the form of an Investigational new drug application.

- (4) The United States Department of Veterans Affairs.
 - (5) The United States Department of Defense.
 - (6) A federally funded general clinical research center.
 - (7) The Coalition of National Cancer Cooperative Groups.
- d. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
 - e. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
 - f. There must be no clearly superior, non-Investigational approach.
 - g. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-Investigational alternative.
 - h. The patient has signed an institutional review board approved consent form.

H. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

- a. Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for training, if prescribed by the Member's treating Provider.
- b. Evaluation and training programs for diabetes self-management are covered, subject to the following:
 - (1) The program must be prescribed by Member's treating Provider and provided by a licensed healthcare professional that certifies that You have successfully completed the training program.
 - (2) The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

2. Diabetic Retinal Screening

Diabetic Members are eligible to receive retinal eye screenings to detect and prevent diabetic retinopathy and other eye complications, once per Benefit Period, at no cost to the Member when services are rendered by a Network Provider. Additional screenings or screenings by a Non-Network Provider are covered subject to contract benefits.

I. Dietitian Visits

Benefits are available for visits to registered dietitians. One (1) dietitian visit is covered at no cost to Members when performed by a Network Provider. All other subsequent dietitian visits are covered at contract benefits. Diabetics that need the service of a Dietitian should receive those services as part of their Benefits for Diabetes Education and Training for Self-Management.

J. Disposable Medical Equipment and Supplies

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

K. Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances, Devices and Services

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances, Services and Devices (Limb and Non-Limb) are covered at the Coinsurance percentages shown in the Schedule of Benefits. Durable Medical Equipment, Orthotic Devices and Non-Limb Prosthetic Appliances and Devices and Prosthetic Services are subject to an aggregate Benefit Period maximum, if shown in the Schedule of Benefits. Prosthetic Appliances and Devices of the limbs and Prosthetic Services of the limbs accrue to the Benefit Period maximum for each limb, 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 You or others. In addition, the equipment must meet all of the following criteria:

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

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

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

c. Limitations in connection with Durable Medical Equipment.

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

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

2. Orthotic Devices

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

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

3. Prosthetic Appliances and Devices (Non-Limb)

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

- a. There is no coverage for fitting or an adjustment, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.
- b. Repair or replacement of the Prosthetic Appliance or Device is covered only after a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time-period.
- c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when You select a deluxe appliance solely for Your 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 We Authorize, and are covered subject to the following:

- a. All Prosthetic Appliances, Devices and Prosthetic Services for limbs accrue to the Benefit Period maximum for each limb and as shown in the Schedule of Benefits.
- 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. We will determine this time-period.
- c. Benefits based on the Allowable Charge for standard appliances will be provided toward any deluxe appliance when a Member selects a deluxe appliance solely for his comfort or convenience. A Member may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Contract 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.

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

L. Emergency Medical Services

1. Hospital Facility Services

- a. A Member must pay an Emergency Room Copayment, Deductible Amount and/or Coinsurance, if shown on the Schedule of Benefits, for each visit the Member makes to a Hospital or Allied Health Facility for Emergency Medical Services.
- b. The Emergency Room Copayment, if shown on the Schedule of Benefits, is waived if the visit results in an Inpatient Hospital Admission.

2. Professional Services

A Member must pay applicable Deductible Amount and/or Coinsurance, if shown on the Schedule of Benefits, for each Provider rendering Emergency Medical Services.

M. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services only: (1) WHEN WRITTEN AUTHORIZATION OF MEDICAL NECESSITY IS GIVEN BY COMPANY PRIOR TO SERVICES BEING PERFORMED; AND (2) SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM COMPANY TO PERFORM YOUR PROCEDURE.

N. Hearing Benefits

Benefits are available for hearing aids for covered Members age seventeen (17) and under when obtained from a Network Provider or another Provider approved by Us. This Benefit is limited to one hearing aid for each ear with hearing loss every 36 months. 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.

We will pay up to Our Allowable Charge for this Benefit. We may increase Our Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. In no event will We pay more than one thousand four hundred dollars (\$1,400.00) per hearing aid, per ear, in a thirty-six (36) month period. If You purchase a hearing aid that costs more than one thousand four hundred dollars (\$1,400.00), You are responsible for all amounts above one thousand four hundred dollars (\$1,400.00). This Benefit is not subject to Copayments, Coinsurance or Deductibles.

Implantable bone conduction hearing aids, cochlear implants and bone-anchored hearing aids (BAHA) are not subject to the above limitation and provisions. They are covered for all eligible Members, regardless of age, the same as any other service or supply, subject to Medical Necessity and payment of applicable Copayments, Coinsurance and Deductibles.

O. High-Tech Imaging

Medically Necessary High-Tech Imaging, including but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology are covered. These services require prior Authorization.

P. Hospice and Home Health Care Benefits

1. Hospice Care is covered up to the maximum number of days per Benefit Period shown in the Schedule of Benefits.
2. Home Health Care services provided to a Member in lieu of an Inpatient Hospital Admission are covered, for the maximum number of visits per Benefit Period shown in the Schedule of Benefits.

Q. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter/transliterater are covered when You need such services in connection with medical treatment or diagnostic consultations performed by a Physician or Allied Health Professional, if the services are required because of hearing loss or Your failure to understand or otherwise communicate in spoken language.

Services rendered by a family Member are not covered.

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

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

Benefits for Low Protein Food Products are limited to the treatment of the following diseases:

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

Benefits shall not exceed two hundred dollars (\$200.00) per month, and are subject to applicable Deductible Amounts, Coinsurance, and/or Copayments as shown on the Schedule of Benefits. You are responsible for all amounts above two hundred dollars (\$200.00) per month. Charges over two hundred dollars (\$200.00) per month are non-covered charges and do not accrue to Your Out-of-Pocket Amount.

S. Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed Physician or received in a Hospital or other public or private facility authorized to provide lymphedema treatment. Coverage includes but is not limited to multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

T. Permanent Sterilization Procedures

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

U. Prescription Drugs

If coverage is available for Prescription Drugs, all Prescription Drugs approved for self-administration (e.g. oral and self-injectable drugs) must be obtained through the Prescription Drug Benefits section of this Contract.

V. Private Duty Nursing Services

1. Coverage is available to You for Private Duty Nursing Services, as shown in the Schedule of Benefits, when performed on an Outpatient basis and when the R.N. or L.P.N. is not related to You by blood, marriage or adoption.
2. Private Duty Nursing Services are subject to the Deductible Amount and Coinsurance percentage shown on the Schedule of Benefits.
3. Inpatient Private Duty Nursing Services are not covered.

W. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage. Only sleep studies performed as a home sleep study or in a network-accredited sleep laboratory are eligible for coverage. Members should check their provider directory or contact a customer service representative at the number listed on his ID card to verify that a sleep laboratory is accredited.

X. Telehealth Services

Benefits are available to You for the diagnosis, consultation, treatment, education, care management, patient self-management, and caregiver support when You and your Provider are not physically located in the same place. Care rendered by Telehealth Services is also available for chronic care management for Members with two or more chronic conditions, and for prolonged preventative services, when more time is needed with the Provider beyond the typical time allotted for the service.

Interaction between Member and Provider may take place in different ways, depending on the circumstances. Telehealth Services generally must be held in real time through an established patient portal by two-way video and audio transmissions simultaneously (Synchronous). Telehealth Services does not cover telephone calls, and only in some circumstances is it allowed by methods other than simultaneous audio and video transmission. It must always be medically appropriate for the setting in which the services are provided.

Interaction in an established Patient-Provider relationship may take place when an established patient sends his pre-recorded video or images to his Provider via video communication, text messaging, email, or an established patient portal (Asynchronous) at the Provider's request, or when the data is transferred between two Providers on the patient's behalf. This method of Telehealth Services is appropriate only in limited circumstances, such as follow-up visit with the Provider within 12 hours of an in-person visit to that Provider.

The amount You pay for a Telehealth Services visit may be different than the amount You would pay for the same Provider's service in a non-Telehealth setting. You will pay more for a Telehealth visit when your Provider is not in your Network.

HMO Louisiana has the right to determine if billing was appropriate and contains the required elements for Us to process the Claim.

Y. Urgent Care Benefits

Services of Urgent Care Centers are covered.

Z. Vision Care

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

ARTICLE XIV.

CARE MANAGEMENT

A. Authorization of Admissions, Services and Supplies, Selection of Provider, and Penalties

1. Selection of Provider

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

- a. If a Member wants to receive services from a Participating or Non-Network Provider and obtain the highest level of Benefits, he must notify Our Care Management Department before services are rendered. We will approve the use of a Participating or Non-Network Provider only if We determine that the services **cannot** be provided by a Network Provider within a 75-mile radius of the Member's home.

We must approve the use of the Non-Network Provider and issue any required Authorization before services are rendered. If We do not approve 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 Provider level shown on the Schedule of Benefits.

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

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

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

If Authorization is not requested prior to Admission or receiving other Covered Services and supplies requiring an Authorization, We 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 Member must pay all charges incurred.

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

a. Admissions

- (1) If a Network Provider or a Participating Provider fails to obtain a required Authorization, We 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 Member remains responsible for any applicable Copayment or his Deductible and Coinsurance percentage shown in the Schedule of Benefits.
- (2) If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown in the Schedule of Benefits. This penalty applies to all covered Inpatient charges. The Member is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage shown in the Schedule of Benefits.

b. 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 thirty percent (30%). 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. The Member remains responsible for his Copayment or Deductible and applicable Coinsurance percentage.
- (2) If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on the Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for his Copayment, Deductible and applicable Coinsurance percentage.

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Member is responsible for ensuring that his Provider notifies Our Care Management Department of any Elective or non-emergency Inpatient Hospital Admission. The Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Member's 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 Company when the Hospital Inpatient setting is documented to be Medically Necessary.

- (1) If a request for Authorization is denied by Us for an Admission to any facility, the Admission is not covered and the Member must pay all charges incurred during the Admission for which Authorization was denied.
- (2) If Authorization is not requested prior to an Admission, We 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 Member 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 Member's responsibility to ensure that his Physician or Hospital, or a representative thereof, notifies the Company's Care Management Department of all Emergency Inpatient Hospital Admissions to guarantee coverage. Within forty-eight (48) hours of the Emergency Admission, the Company must be notified (by calling the telephone number shown in the Schedule of Benefits or the Member's ID card) regarding the nature and purpose of the Emergency Admission. The Company may waive or extend this time limitation if it determines that the Member is unable to timely notify or direct his representative to notify the Company of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend, the Company must be notified on its next working day. The appropriate length of stay for the Emergency Admission will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.

- (1) If Authorization is denied by Us for an Admission to any facility, the Admission will not be covered and the Member must pay all charges incurred during the Admission for which Authorization was denied.
- (2) If Authorization is not requested, We 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 Member 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 We Authorize a Member's Inpatient stay, We will Authorize his stay in the Hospital for a certain number of days. If the Member has not been discharged on or before the last Authorized day, and the Member needs additional days to be Authorized, the Member must make sure his Physician or Hospital contacts Our Care Management Department to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Member's last Authorized day so We can review and respond to the request that day.

If We Authorized the request, We will again Authorize a certain number of days, repeating this procedure until the Member is either discharged or the Member's continued stay request is denied.

- (1) If We do not receive a request for Authorization for continued stay on or before the Member's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless We receive and Authorize another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and We determine that it is not Medically Necessary for the Member to receive continued hospitalization or hospitalization at the level of care requested, We will notify the Member and his Providers, in writing, that the request is denied and no additional days are Authorized.
- (2) If We deny a Concurrent Review request or level of care request for Hospital Services, We will notify the Member, his Physician and the Hospital of the denial. If the Member elects to remain in the Hospital as an Inpatient thereafter, or at the same level of care, the Member will not be responsible for any charges unless he is notified of his financial responsibility by the Physician or Hospital in advance of incurring additional charges.
- (3) Charges for non-authorized days in the Hospital that the Member must pay are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

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

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

- a. If a request for Authorization is denied by Us, the Outpatient services and supplies are not covered.
- b. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, We will have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider.
- c. Additional amounts for which the Member 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.

B. Disease Management

1. Qualification - You may qualify for Disease Management programs, at Our discretion, based on various criteria, including a diagnosis of chronic illness, severity, and proposed or rendered treatment. The program seeks to identify candidates as early as possible. Self-management techniques are reinforced and a personal nurse is assigned. You or Your Physicians and caregivers may be included in all phases of the disease management program. The disease management nurse may also refer You to community resources for further support and management.
2. Disease Management Benefits - HMO Louisiana, Inc.'s Disease Management programs are committed to improving the quality of care for You as well as decreasing healthcare costs in populations with a chronic disease. The nurse works with You to help You learn the self-care techniques You will need in order to manage Your chronic disease, establish realistic goals for life style modification, and improve adherence to Your Physician's prescribed treatment plan. HMO Louisiana, Inc. is dedicated to supporting the Physician's efforts in improving Your health status and well-being.

C. Case Management

1. You may qualify for Case Management services, at Our 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.
2. The role of Case Management is to service You 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. Our determination that a particular Member's medical condition renders the Member a suitable candidate for Case Management services will not obligate Us to make the same or similar determination for any other Member: The provision of Case Management services to one Member will not entitle any other Member to Case Management services or be construed as a waiver of Our right to administer and enforce the Contract in accordance with its express terms.
4. Unless expressly agreed upon by the Company, all terms and conditions of the Contract, 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 You are receiving Case Management services.
5. Your Case Management services will be terminated upon any of the following occurrences:
 - a. We determine in Our sole discretion, that You are 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 You elect not to participate in the Case Management plan.

D. Alternative Benefits

1. You may qualify for Alternative Benefits, at Our 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 You and to the Company.
2. Our determination that a particular Member's medical condition renders the Member a suitable candidate for Alternative Benefits will not obligate Us to make the same or similar determination for any other Member; nor will the provision of Alternative Benefits to a Member entitle any other Member to Alternative Benefits or be construed as a waiver of Our right to administer and enforce this Contract in accordance with its express terms.

- d. to the extent payment has been made or is available under any other contract issued by HMO Louisiana, Inc. or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited Benefit policies;
 - e. which are Investigational in nature, except as specifically provided in this Contract. Investigational determinations are made in accordance with Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;
 - f. rendered as a result of occupational or work-related disease or injury compensable under any federal or state workers' compensation law or similar type legislation;
 - g. received from a dental or medical department maintained by or on behalf of an employer, a mutual Benefit association, labor union, trust, or similar person or Group; or
 - h. rendered by a Provider who is the Subscriber's Spouse, child, stepchild, parent, stepparent or grandparent.
 - i. Telephone calls, video communication, text messaging, e-mail messaging, instant messaging, or patient portal communications between You and your Provider unless specifically stated as covered under the Telehealth Services Benefit. Services billed with Telehealth codes not medically appropriate for the setting in which the services are provided. Telehealth Services between You and a Certified Nurse Assistant, Licensed Perfusionist, Licensed Radiology Technician, or Licensed Clinical Laboratory Scientist.
 - j. for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records of information required to adjudicate a Claim, or for access to or enrollment in or with any Provider;
 - k. for services performed in the home unless the services meet the definition of Home Health, or otherwise covered specifically in this policy, or are approved by Us;
 - l. for any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan; or
 - m. for paternity tests and test performed for legal purposes.
5. Benefits are excluded for 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. This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Benefits are available to the Member for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or in case of emergency care, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition.
 - e. for treatment of any Member detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.

6. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, surgery, supplies, treatment, or expenses in connection with or related to, or Complications from the following:
- a. rhinoplasty;
 - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
 - c. gynecomastia;
 - d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Contract;
 - 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, except those the law requires Us to cover or those We offer, endorse, approve, or promote, as part of Your healthcare coverage under this Benefit Plan. Some of these programs may be offered as value-added programs and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs.
 - j. Diabetes prevention programs unless approved by Us and limited to once every thirty-six (36) months.
 - k. treatment related to erectile or sexual dysfunctions, low sexual desire disorder or other sexual inadequacies;
 - l. 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;
 - m. recreational therapy;
 - n. Inpatient pain rehabilitation or Inpatient pain control programs; and/or
 - o. primarily to enhance athletic abilities.
7. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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 Contract;
 - 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. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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 Contract;
 - 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 Contract.
 - e. Gene Therapy or Cellular Immunotherapy if prior Authorization is not obtained or if the services are performed at an administering Facility that has not been approved in writing by Company prior to services being rendered.
9. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any of the following, except as specifically provided for in this Contract or in the Schedule of Benefits:
- a. weight reduction programs;
 - b. bariatric surgery procedures including, but not limited to:
 - (1) Roux-en-Y gastric bypass
 - (2) Laparoscopic adjustable gastric banding
 - (3) Sleeve gastrectomy
 - (4) Duodenal switch with biliopancreatic diversion;
 - c. removal of excess fat or skin, regardless of Medical Necessity, or services at a health spa or similar facility; or
 - d. obesity or morbid obesity, regardless of Medical Necessity.
10. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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 Contract.
11. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services or supplies for the treatment of eating disorders, unless otherwise required by law.
12. Benefits are excluded for 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. 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 along with all Medically Necessary services associated with the administration of the drug, 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 or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by Us;
- d. fertility drugs;
- e. nutritional or dietary supplements, or herbal supplements and treatments (Low Protein Food Products are covered as described in this Contract);
- f. prescription vitamins not listed as covered in the Prescription Drug Formulary (including but not limited to Enlyte);
- g. drugs that can be lawfully obtained without a Physician's order, including over-the-counter ("OTC") drugs, except those required to be covered by law;
- h. selected Prescription Drugs for which an OTC-equivalent or for which a similar alternative exists as an OTC medication;
- i. contraceptive drugs;
- j. all methods of contraception that do not result in permanent sterilization;
- k. refills in excess of the number specified by the Physician or the dispensing limitation described in this Contract, 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;
- l. any drugs used for smoking cessation except Zyban;
- m. 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;
- n. selected Prescription Drug products that contain more than 1 active ingredient (sometimes called combination drugs);
- o. Prescription Drug products that include or are packaged with a non-Prescription Drug product;
- p. Prescription Drug compounding kits;
- q. selected Prescription Drug products that are packaged in a way that contains more than one Prescription Drug;
- r. Prescription Drug products that contain marijuana, including medical marijuana;

- s. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;
 - t. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;
 - u. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®), low sexual desire disorder (Addyi®) or other sexual inadequacies;
 - v. 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;
 - w. growth hormone therapy, except for the treatment of chronic renal insufficiency, AIDS wasting, Turner's Syndrome, Prader-Willi syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms the growth hormone deficiency with abnormal provocative stimulation testing;
 - x. Prescription Drugs for and/or treatment of idiopathic short stature;
 - y. 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;
 - z. topically applied prescription drug preparations that are approved by the FDA as medical devices;
 - aa. Prescription Drugs subject to the Step Therapy program when the Step Therapy program was not utilized or the drug was not approved by Us or Our pharmacy Benefit manager;
 - bb. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider unless the provider is contracted with Our pharmacy Benefit manager;
 - cc. covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include, but are not limited to intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as determined by Us are covered under the medical Benefit and excluded under the pharmacy Benefit; and
 - dd. 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 Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Member's Copayment, in which case, the Member must pay the Prescription Drug cost and sales tax.
13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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.
14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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.

15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any abortion other than to save the life of the mother.
16. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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.
17. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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.
18. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.
19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a covered Member related to:
 - a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Member or as required by law;
 - b. Pre-implantation genetic diagnosis;
 - c. Preconception carrier screening; and
 - d. Prenatal carrier screening except screenings for cystic fibrosis.
20. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for hospital, surgical or medical services rendered in connection with the pregnancy of a covered Dependent child or grandchild.
21. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.
22. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Cosmetic Surgery, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly or Mastectomy. Complications resulting from any of these or any other non-covered items are excluded.
23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Contract under Oral Surgery Benefits. This exclusion does not apply to Cleft Lip and Cleft Palate Services.
24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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. This exclusion does not apply to Cleft Lip and Cleft Palate Services.
25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for 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 Contract.

26. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for travel expenses of any kind or type other than covered Ambulance Services to the closest hospital equipped to adequately treat your condition. Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Members traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to your home country and air/sea travel when ambulance is not required.
27. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and learning disabilities. This includes Applied Behavior Analysis (ABA) services. This exclusion for educational services and supplies does not apply to training and education for diabetes.
28. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Applied Behavior Analysis.
29. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.
30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.
31. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services or supplies for Preventive or Wellness Care and/or Well Baby Care, except as specifically provided in this Contract.
32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for Hospital charges for a well newborn, except as specifically provided in this Contract.
33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for services or supplies for the treatment of Mental Disorders or alcohol and/or drug abuse. Behavioral health services for any and all diagnoses, except as specifically provided in this Contract.
34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.
35. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP).
36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for reversal of a voluntary sterilization procedure.
37. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by Us.
38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Benefits are excluded for sleep studies, unless performed as a home sleep study or in a network-accredited sleep laboratory. If a sleep study is not performed by a network-accredited sleep laboratory, as a home sleep study or a sleep study is denied, then neither the sleep study nor any professional Claims associated with the sleep study are eligible for coverage.

ARTICLE XVI.

GENERAL PROVISIONS

A. This Contract

1. This Contract, including the Application for Coverage expressing the entire money and other consideration therefore, the Schedule of Benefits, any Riders and any amendments or endorsements, constitutes the entire contract between the parties.
2. This Contract is guaranteed renewable at the Subscriber's option. Subscriber indicates his desire to continue coverage by his timely payment of each premium as it becomes due. We shall renew or continue coverage under this Contract on a month-to-month basis, at Your option.
3. The Company reserves the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Contract. Any function to be performed by the Company under this Contract may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.
4. Our liability is limited to the Benefits specified in this Contract. Benefits for Covered Services specified in this Contract will be provided only for services and supplies rendered on and after Your Effective Date by a Provider specified in this Contract and regularly included in such Provider's charges.
5. Continuity of healthcare services.
 - a. Upon the termination of a contractual agreement with a Provider, notification of the removal of the Provider from the HMOLA Provider Network will be given by Us to a Member who has begun a course of treatment by the Provider.
 - b. A Member has the right to continuity of care applicable to the following provisions and subject to consent of the treating Provider:
 - (1) In the event the Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth (24th) week of pregnancy, the Member shall be allowed to continue receiving Covered Services through delivery and postpartum care related to the pregnancy and delivery.
 - (2) In the event the Member has been diagnosed with a Life-Threatening Illness, the Member shall be allowed to continue receiving Covered Services until the course of treatment is completed, not to exceed three (3) months from the effective date of termination of the Provider's contractual agreement.
 - c. The provisions of continuity of care shall not be applicable if any one of the following occurs:
 - (1) The reason for termination of a Provider's contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.
 - (2) The Member voluntarily chooses to change Providers.
 - (3) The Member relocates to a location outside of the geographic service area of the Provider or the HMOLA Provider Network.
 - (4) The Member's chronic condition only requires routine monitoring and is not in an acute phase of the condition.

B. Section 1557 Grievance Procedure

HMO Louisiana, Inc. does not discriminate on the basis of race, color, national origin, sex, age or disability. HMO Louisiana, Inc. has adopted an internal grievance procedure providing for prompt resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator, who has been

designated to coordinate the efforts of HMO Louisiana, Inc. to comply with Section 1557 at the following address:

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238
800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability, You may file a grievance under this procedure. It is against the law for HMO Louisiana, Inc. to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date You become aware of the alleged discriminatory action.
- A complaint must be in writing, containing Your name and address. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator will investigate the complaint. This investigation may be informal, but it will be thorough. You are encouraged to submit evidence related to Your complaint. The Section 1557 Coordinator will maintain the files and records of HMO Louisiana, Inc. relating to such grievances. To the extent possible, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after it is received.
- You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within 15 days of receiving the Section 1557 Coordinator's decision. The Section 1557 Grievance Administrator shall issue a written decision in response to the appeal no later than 30 days after it is received.

The availability and use of this grievance procedure does not prevent You from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the United States Department of Health and Human Services, Office for Civil Rights. You can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

United States Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

HMO Louisiana, Inc. will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

C. Non-Responsibility for Acts of Providers

We will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or 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 Your care or treatment.

D. Contract Changes

Subject to all applicable laws, We reserve the unlimited right to modify the terms of this Contract in any way. Changes will be effective upon renewal of the Contract and preceded by not less than sixty (60) days notice to You. We will issue to You an amendment to this Contract specifying the modification of the terms of this Contract as well as the Effective Date of the amendment. No change or waiver of any Contract provision will be effective until approved by Our chief executive officer or his delegate.

E. Identification Cards

We will issue an identification (ID) card to You. You must present Your identification card whenever Covered Services are rendered. Identification cards are not transferable. Unauthorized use of the identification card by any person can result in termination of Your coverage. The identification card serves only to identify the covered Member and confers no right to Covered Services or Benefits.

To be entitled to Covered Services or Benefits an ID cardholder must be a Member on whose behalf all applicable premiums have actually been paid. A Member must carry the ID card with them at all times to assure prompt receipt of Covered Services. If a card is lost or stolen, please notify Us immediately.

F. Due Date for Premium Payments

1. Premiums are due and payable in advance from Subscriber, prior to the coverage being rendered. Premiums are due and payable beginning on the Effective Date of the first Policy Year of this Contract and on the same date each month thereafter. This is the premium due date. This policy is renewable on a monthly basis by the timely payment of each premium as it becomes due.
2. Premiums are owed by Subscriber. Premiums may not be paid by third parties unless related to the Subscriber by blood or marriage. Premiums may not be paid by Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. Company will not accept premium payments by third parties unless required by law to do so. The fact that We may have previously accepted a premium from an unrelated third party does not mean that we will accept premiums from these parties in the future.
3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean we will accept late a premium in the future. You may not rely on the fact that we may have previously accepted a late premium as indication that We will do so in the future.
4. Premiums must be paid in US dollars. Policyholder will be assessed a twenty-five dollar (\$25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage.

G. Change in Premium Amount

1. If Your age was misstated, any amount payable or any indemnity accruing under this Contract shall be such as the premium paid would have purchased at the correct age. If because of a misstatement of age this Contract was issued at an age or was continued or renewed beyond an age at which it would not have been issued, continued or renewed, under Our underwriting rules in effect at the date of issue, the amount payable hereunder on account of loss occurring after such age, shall be limited to a return of the premiums paid thereafter. A clerical error will not void insurance, which should be in force nor will it continue insurance that should have ended.

2. We reserve the right to increase the premiums for this Contract after the first Policy Year (twelve (12) months of coverage) and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give forty-five (45) days written notice to You of a premium change, at Your last address shown in Our records. Any increase in premium will become effective on the date specified in the notice. Continued payment of premium will constitute acceptance of the change.
3. We reserve the right to increase premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Contract. This risk includes, but is not limited to, the addition of a newly covered person. Additionally, We reserve the right to increase the premium if You request a change in policy Benefits from that which was in force at the time of the last rate determination. Such increase in premium will become effective on the next billing date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

H. Subscriber's Right to Cancel This Contract

1. Subscriber may cancel this Contract for any reason.
2. To cancel the policy, Subscriber must give Company WRITTEN NOTICE of his intent to cancel. Written notice should be sent to the Company at the home office, attention "Individual Membership and Billing":

HMO Louisiana, Inc.
Attention: Individual Membership and Billing
P. O. Box 98029
Baton Rouge, LA 70898-9029

3. Subscriber may not verbally cancel this coverage. Subscriber's written notice of cancellation must be given to Company prior to or on the effective date of the cancellation and must be accompanied by the return of the insurance policy. If Subscriber's written notice to Company of his intent to cancel is not accompanied by the surrendered policy, Subscriber's cancellation notice to Company shall be deemed to include Subscriber's declaration that the Subscriber made a good faith attempt to locate his policy and the policy is not being returned because it has been lost or destroyed.

I. Company's Right to Terminate This Contract for Nonpayment of Premium

1. Premiums are to be prepaid before coverage is rendered. The Subscriber is considered delinquent if premiums are not paid on the due date.
2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the policy. If We do not receive the premium during the grace period, We will mail a delinquency/lapse notice to the Subscriber's address of record. We may also mail a termination notice to the Subscriber's address of record, We may automatically terminate the policy without further notice to the Subscriber if we do not receive Subscriber's premium at Our home office within thirty (30) days of the due date (during the grace period). If we terminate this Contract for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

J. Company's Right to Rescind Coverage, Terminate or Non-Renew the Contract for Reasons Other Than Nonpayment of Premium

1. Causes for the rescission (retroactive termination) of this Contract:
 - a. Subscriber or a covered Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Contract. The issuance of this Contract is conditioned on the representations and statements contained on the application, a copy of which is attached to and made a part of this Contract. Representations made on the application are material to the issuance of this Contract. All representations made on the application are material to the

issuance of this Contract. Any information intentionally omitted from the application, as to any proposed Subscriber or covered Member shall constitute an intentional misrepresentation of material fact. If you enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

- b. Subscriber fails to comply with a material plan provision or obligation under this Contract, including, but not limited to provisions relating to eligibility.
 - c. In the case of network plans, You no longer live, reside, or work in Our service area in or in the service area for which We are authorized to do business.
 - d. Company ceases to offer this product or coverage in the market.
2. If Company decides to rescind this coverage because of a. above, Company will give Subscriber thirty (30) days advance written notice by certified mail and will include the reason for rescission. Rescission would be retroactive to the Effective Date of coverage.
 3. If Company decides to terminate or not renew this coverage because of b, Company will give Subscriber sixty (60) days advance written notice by certified mail and will include the reason for termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.
 4. If Company decides to terminate or not renew this coverage because of d, Company will give Subscriber written notice by regular mail ninety (90) days in advance of the termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

K. Termination of a Member's Coverage

1. All coverage will end at the end of the period for which premiums have been paid. No Benefits are available to You for Covered Services rendered after the date of termination of Your coverage. However, if You or Your Dependent is an Inpatient in a Hospital on the date of termination, medical Benefits in connection with the Admission for that patient will terminate at the end of that Admission or upon reaching any Benefit limitations set in this Contract, whichever occurs first.
2. Subscriber has an obligation to notify Us, within 15 days, when Dependents die or need to be taken off the Contract for any reason. We will re-calculate premiums so Subscriber pays the proper amount. No refunds will be made to Subscriber if Subscriber fails to give timely notice when a Dependent ceases to be eligible to keep coverage or when a Dependent's coverage should have been terminated.
3. Coverage for Subscriber's Spouse terminates automatically, without notice, at the end of the period for which premiums have been paid, when a final decree of divorce or other legal termination of marriage is rendered. Subscriber has an obligation to notify Us, within 15 days, after a final decree of divorce or other legal termination of marriage is rendered.
4. Coverage for Dependents terminates automatically, without notice, at the end of the year the Dependent ceases to be an eligible Dependent, unless it is specifically otherwise stated in this Contract or as provided by law. Premiums are required to be paid in order to retain coverage until the Dependent ceases to be eligible.
5. Upon the death of the Subscriber, all coverage on this Contract ends for all covered persons on the Contract. Termination is automatic and without notice. Termination is effective at the end of the billing period in which the Subscriber's death occurred, if premiums have been paid through that billing cycle.
6. If the Spouse or other covered Dependents wish to continue coverage, he must notify Us of his desire to continue coverage. Notification must be received by a Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. office within thirty (30) days after the date of termination. If notification is received within thirty (30) days of the termination, the Member's coverage will be established on a separate policy and the Member will not be subject to evidence of insurability.

7. In the event that You move outside Our Service Area with the intent to relocate or establish a new residence outside Our Service Area, Your coverage will be terminated.
8. We reserve the right to automatically change the class of coverage on this Contract to reflect the membership on the Contract.

L. Filing of Claims

1. You must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.
2. Most Members that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for You. However, if You must file a Claim to access Your Prescription Drug Benefit, You must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The claim form should then be sent to Our Pharmacy Benefit Manager, whose telephone number should be found on Your ID card.

M. Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.
2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of this Contract.

N. Release of Information

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

O. Assignment

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

P. Member/Provider Relationship

1. The choice of a Provider is solely Yours.
2. We and all Network Providers are to each other independent contractors, and will not be considered agents, representatives, or employees of each other for any purpose whatsoever. HMO Louisiana, Inc. does not render Covered Services but only makes payment for Covered Services You receive. We are not liable for any act or omission of any Provider, or for any claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any Network Provider or in any Network Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to You.
3. Use or non-use of an adjective such as Network or Non-Network referring to a Provider is not a statement as to the ability of the Provider.

Q. Applicable Law

This Contract will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law. This Contract is not subject to regulation by any state other than the State of Louisiana. If any provision of this Contract is in conflict with any applicable statutes of the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

R. Notice

Any notice required under this Contract must be in writing. Notice given to You will be sent to Your address stated in the Application for Individual Health Coverage. Notice given to Us will be sent to Our address stated in this Contract. Any notice required to be given will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to You at Your address as the same appears on Our records. You or We may, by written notice, indicate a new address for giving notice.

S. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Contract, We will be subrogated and will succeed to Your right for the recovery of the amount paid under this Contract against any person, organization or other carrier even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover shall be subordinate to the Member's right to be "made whole." We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually incurred by the Member in pursuing recovery.
2. You will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured, to the extent of the Benefits provided or paid under this Contract. Our right to reimbursement shall be subordinate to Your right to be "made whole." We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.
3. You will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interest under this Contract. We or Our designees have the right to obtain and review Your medical and billing records, if We determine in Our sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement.
4. You are required to notify Us of any Accidental Injury.

T. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that exceeds the maximum Benefits available for such services under this Contract, or whenever payment has been made in error by Us for non-Covered Services, We will have the right to recover such payment from You or, if applicable, the Provider. We reserve the right to deduct from any pending Claim for payment under this Contract any amounts that We are owed by You or the Provider.

U. 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 Us to the extent the veteran would be eligible for Benefits for such care or services from Us 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 Us the reasonable cost of healthcare 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 Us 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.

V. Liability of Plan Affiliates

You expressly acknowledge Your understanding that the agreement constitutes a Contract solely between You and HMO Louisiana, Inc., that HMO Louisiana, Inc. 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 HMO Louisiana, Inc. to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that HMO Louisiana, Inc. is not contracting as the agent of the Association. You further acknowledge and agree that You have not entered into this Contract based upon representations by any person other than HMO Louisiana, Inc. and that no person, entity, or organization other than HMO Louisiana, Inc. shall be held accountable or liable to You for any of HMO Louisiana, Inc.'s obligations to You created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of HMO Louisiana, Inc. other than those obligations created under other provisions of this Contract.

W. Certificates of Creditable Coverage

We will issue a certificate of Creditable Coverage or similar document to an individual, if requested within twenty-four (24) months after coverage under this Contract ceases.

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

We shall provide to certain individuals who have Prescription Drug coverage under this Contract, without charge, a written certification that their Prescription Drug coverage under this Contract is either creditable or non-creditable. Coverage is deemed creditable if it is at least as good as the standard Medicare Part D prescription drug Benefit. We will give these certificates to Covered individuals who are eligible for Medicare Part D based on enrollment data provided to Us by the Subscriber or Member.

We will provide Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to Covered Members at the following times, or as designated by law;

1. Prior to the Medicare Part D Annual Coordinated Election Period;
2. Prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D;
3. Whenever Prescription Drug coverage under this Contract ends;
4. Whenever Prescription Drug coverage under this Contract changes so that it is no longer creditable or becomes creditable; and/or
5. Upon a Medicare beneficiary's request.

Y. Out-of-Area Services

HMO Louisiana, Inc. ("HMOLA") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever You obtain healthcare services outside of Our Service Area, the Claims for those services may be processed through one of these Inter-Plan Arrangements.

When You receive care outside HMOLA's Service Area and the service area of Blue Cross and Blue Shield of Louisiana, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

This point-of-service Contract covers healthcare services received outside of HMOLA's Service Area, but pays Non-Network Benefits at a lower level. As used in this section, "Out-of-Area Covered Services" includes most, but not all Covered Services obtained outside the geographic area We serve. Organ, tissue and bone marrow transplants obtained from Non-Network Providers will not be covered when processed through any Inter-Plan Arrangements, unless both the services and use of a Non-Network Provider are Authorized by HMOLA prior to You receiving these services.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, except for all Dental Care Benefits when paid as medical Benefits, and those Prescription Drug Benefits or vision care Benefits that may be administered by a third party contracted by Us to provide the specific service or services.

1. BlueCard® Program

Under the BlueCard® Program, when You receive Out-of-Area Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard® Program enables You to obtain Out-of-Area Covered Services from a healthcare Provider participating with a Host Blue, where available. The Participating Provider will automatically file a Claim for the Out-of-Area Covered Services provided to You, so there are no claim forms for You to fill out. You will be responsible for obtaining any required Authorizations and payment of applicable Copayments, Deductible Amount and Coinsurance, as stated in Your Schedule of Benefits.

Emergency Medical Services: If You experience a medical Emergency while traveling outside the HMOLA Service Area, go to the nearest Emergency facility.

When You receive Out-of-Area Covered Services outside HMOLA's Service Area and the service area of Blue Cross and Blue Shield of Louisiana and the Claim is processed through the BlueCard® Program, the amount You pay for the Out-of-Area Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

- the billed charges for Your Out-of-Area Covered Services; or
- the negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your 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 also take into account adjustments to correct for over- or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price We have used for Your Claim because they will not be applied after a Claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any such surcharge, tax or other fee as part of the Claim charge passed on to You.

2. Non-Participating Providers Outside Our Service Area

a. Member Liability Calculation

When Out-of-Area Covered Services are provided outside of HMOLA's Service Area and the service area of Blue Cross and Blue Shield of Louisiana by Non-Participating Providers, the amount You pay for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Out-of-Area Covered Services as set forth in Your Contract. Federal or state law, as applicable, may govern payments for Non-Network Emergency Medical Services.

b. Exceptions

In certain situations, We may use other payment methods, such as billed charges for Out-of-Area Covered Services, the payment We would make if the healthcare services had been obtained within Our Service Area, or a special negotiated payment to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Out-of-Area Covered Services as set forth in Your Contract.

3. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard® service area"), You may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists You with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard® service area, You will typically have to pay the Providers and submit the Claims Yourself to obtain reimbursement for these services. If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact Us to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Contract.

b. Outpatient Services

Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require You to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global® Core Claim

When You pay for Covered Services outside the BlueCard® service area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of Your Claim. The claim

form is available from Us, the Blue Cross Blue Shield Global® Core service center, or online at www.bcbsglobalcore.com. If You need assistance with Your Claim submission, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

ARTICLE XVII. COORDINATION OF BENEFITS

A. Applicability

1. This Coordination of Benefits (“COB”) section applies to This Plan when a Member has healthcare coverage under more than one Plan. “Plan” is defined below.
2. This Section is intended to describe the order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

B. Definitions (Applicable only to this Article of this Contract)

1. “Allowable Expense” means any healthcare service or expense, including deductibles, coinsurance or copayments, that is covered in full or at least in part by any Plan covering the person.
 - a. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid.
 - b. An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.
 - c. The following are examples of expenses that are not Allowable Expenses.
 - (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - d. The following are examples of expenses that are Allowable Expenses.
 - (1) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan’s payment arrangement shall be the allowable expense for all plans.
 - (2) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

2. "Closed Panel Plan" a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.
3. "Coordination of Benefits or COB Provision" the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
4. "Custodial Parent"
 - a. the parent awarded custody of a child by a court decree; or
 - b. in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
5. "Order of Benefit Determination Rules" determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.
6. "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - a. Plan includes:
 - (1) Group and non-group Insurance Contracts;
 - (2) Health maintenance organization (HMO);
 - (3) group and non-group coverage through closed panel plans;
 - (4) Group-Type Contracts (whether insured or uninsured);
 - (5) the medical care components of long-term care contracts, such as skilled nursing care;
 - (6) the medical benefits under group or individual automobile contracts;
 - (7) Medicare or other governmental benefits, as permitted by law.
 - b. Plan does not include:
 - (1) hospital indemnity coverage benefits or other fixed indemnity coverage;
 - (2) accident only coverage;
 - (3) specified disease or specified accident coverage;
 - (4) limited benefit health coverage as defined by state law;
 - (5) school accident-type coverage except those enumerated in LSA-R.S. 22:1000 A.3C;
 - (6) benefits provided in long-term care insurance policies for non-medical services;
 - (7) Medicare supplement policies;

- (8) a state plan under Medicaid; or
- (9) coverage under other federal government plans, unless permitted by law.

Each contract for coverage under a or b, listed above, is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

C. Order of Benefit Determination Rules

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:
 - a. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
 - (1) Except as provided in Paragraph (2) below, a Plan that does not contain a coordination of benefits provision that is consistent with this Section is always primary unless the provisions of both Plans state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
 - b. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan
2. Each Plan determines its order of benefits using the first of the following rules that apply:
 - a. Non-Dependent or Dependent Rule. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, Subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - b. Dependent Child Covered Under More Than One Plan Rules. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (a) The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary plan; or
 - (b) If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary plan.
 - (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those

terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

- (b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
 - (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
 - (d) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - i. The Plan covering the Custodial parent;
 - ii. The Plan covering the spouse of the Custodial parent;
 - iii. The Plan covering the non-custodial parent; and then
 - iv. The Plan covering the spouse of the non-custodial parent.
- (3) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraphs (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.
- (4) For a dependent child covered under the spouse's plan:
- (a) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the Longer or Shorter Length in Coverage Rule applies.
 - (b) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (1) to the dependent child's parent(s) and the dependent's spouse.
- c. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2) can determine the order of benefits.
- d. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2) determine the order of benefits.
- e. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an employee, member, policyholder, Subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

- f. **Fall-Back Rule.** If none of the preceding rules determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, This Plan will never pay more than it would have paid had it been the Primary plan.

D. Effects on the Benefits of This Plan

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible, coinsurance, copayments and any amounts it would have credited to its deductible in the absence of other health care coverage. In any event, This Plan will never pay more than it would have paid had it been the Primary plan.
2. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
3. If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.
 - a. determine its obligation to pay or provide benefits under its contract;
 - b. determine whether a benefit reserve has been recorded for the covered person; and
 - c. determine whether there are any unpaid allowable expenses during that claims determination period.
4. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

You may request a copy in either paper form or electronic form of Appendix C, which provides an explanation for secondary plans on the purpose and use of the benefit reserve and how secondary plans calculate claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at [<https://www.lidi.la.gov/>].

E. Summary

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines your benefits.

1. Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses. Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2. Primary or Secondary

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain your state’s COB rules will always be primary.

3. When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

- a. The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired;
- b. The claim is for your spouse, who is covered by Medicare, and you are not both retired;
- c. The claim is for the healthcare expenses of your child who is covered by This Plan and:
 - (1) You are married and your birthday is earlier in the year than your spouse’s or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual’s birthday. This is known as the birthday rule.
 - (2) You are separated or divorced and you have informed us of a court decree that makes you responsible for the child’s health care expenses; or
 - (3) There is no court decree, but you have custody of the child.

4. Other Situations

- a. We will be primary when any other provisions of state or federal law require us to be. When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan
- b. We will be secondary whenever the rules do not require us to be primary. When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An “allowable expense” is a health care service or expense covered by one of the plans, including copayments, coinsurance and deductibles.
 - (1) If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
 - (2) We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
 - (3) If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
 - (4) We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

c. **Benefit Reserve**

When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

F. Right to Receive and Release Needed Information

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

G. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. To the extent, such payments are made; they discharge Us 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.

H. Right of Recovery

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

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. other organizations.

ARTICLE XVIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Member is dissatisfied about the care or services he receives from Blue Cross and Blue Shield of Louisiana or one of Our Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

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

Your Appeal rights are outlined below, after the Complaint and Grievance procedures. In addition to the Appeals rights, the Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern Medical Necessity determinations.

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

A. Complaint, Grievance, and Informal Reconsideration Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Our Network Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Members may call the Customer Service Department at 1-800-376-7741 or 1-225-293-0625 to register a Complaint. We will attempt to resolve the Member's Complaint at the time of his call.

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, the Member must submit this in writing within 180 days of the event that led to the dissatisfaction. Our Customer Service Department will assist the Member if necessary.

The Member should send his written Grievance to:

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

A response will be mailed to You within thirty (30) business days after We receive Your written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is the Member Provider's telephone request to speak to Our Medical Director or a peer reviewer on the Member's behalf about a Utilization Management decision that We have made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

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

B. Appeal Procedures

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

If a Member is not satisfied with Our denial of services, a written request to Appeal must be submitted within one hundred eighty (180) days following receipt of the initial adverse Benefit determination.

The Member is encouraged to submit written comments, documents, records, and other information relating to the Claim for Benefits. We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his Claim for Benefits.

The Appeals procedure has two (2) levels, including review by a committee at the second level on an Administrative Appeal and a review by an external Independent Review Organization (IRO) on a Medical Appeal.

The Member may call Us if they have questions or need assistance putting their Appeal in writing, the Member may call Our Customer Service Department at 1-800-376-7741 or 1-225-293-0625.

C. Standard Appeal Process

We will determine if a Member's Appeal is either an administrative Appeal or a medical Appeal. The Appeals procedure has two (2) levels, including review by a committee at the second level on an administrative Appeal and a review by an external Independent Review Organization (IRO) on a medical Appeal.

The Member has the right to appoint an authorized representative to represent him in his Appeals. An authorized representative is a person to whom the Member has given written consent to represent him in an internal or external review of a denial. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing.

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 a denial or partial denial (adverse Benefit determinations) based on the Contract limitations or exclusions and Rescissions of coverage. Administrative Appeals should be submitted in writing to:

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

a. First Level Administrative Appeals

If the Member is not satisfied with Our denial of services, The Member, his authorized representative, or a Provider authorized to act on the Member's behalf, must submit an initial written request to Appeal within one hundred eighty (180) days following receipt of an initial adverse Benefit determination. Requests submitted to Us after one hundred eighty (180) days of receipt of Our initial denial will not be considered.

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

b. Second Level Administrative Appeals

Not applicable to a Rescission of coverage Appeal, which follows the External Appeals track.

After review of Our first level appeal decision, if a Member is still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of Our first level Appeal decision. Requests submitted to Us after sixty (60) days of the denial will not be considered.

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

2. Medical Appeals

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

a. First Level Internal Medical Appeals

If the Member is not satisfied with Our denial of services, the Member, 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 Member's receipt of an initial adverse Benefit determination. Medical Appeals should be submitted in writing to:

HMO Louisiana, Inc.
Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

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

We will investigate Your concerns. All Medical Necessity Appeal denials will be reviewed by a Physician or other healthcare professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. If Our initial denial is overturned on the Member's Medical Necessity Appeal, We will process the Claim and will notify the Member and all appropriate Providers, in writing, of the internal Appeal decision. If Our initial denial is upheld, We will notify the Member and all appropriate Providers, in writing, of Our decision and advise the Member of their right to request an External Appeal. The decision will be mailed within thirty (30) days of the Member's request, unless the Member, their authorized representative and We mutually agree that an extension of the time is warranted. At that time, We will inform the Member of their right to begin the External Appeal process if the Claim meets the criteria.

b. External Medical and Rescission of Coverage

If a Member still disagrees with the Appeals denial, the Member may request an independent External Appeal conducted by a non-affiliated Independent Review Organization (IRO), which will be randomly assigned by the Louisiana Department of Insurance. Within four (4) months of receipt of the initial Appeal decision, the Member should send his written request for an External Review to:

HMO Louisiana, Inc.
Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

Requests submitted to Us after four (4) months of receipt of the internal medical Appeal decision or Rescission of Coverage will not be considered. You are required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. Appeal submitted by your Provider will not be accepted without this form completed with Your signature.

We will provide the IRO all pertinent information necessary to conduct the Appeal. The IRO decision will be considered a final and binding decision on both the Member and Us. The IRO review will be completed within forty five (45) days of Our receipt of the request. The IRO will notify the Member or his authorized representative and his healthcare Providers of its decision.

You may contact the Commissioner of Insurance directly for assistance.

Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

c. Expedited Internal Medical Appeal

We provide an Expedited Internal Appeal process for review of an Adverse Determination involving a situation where the time frame of the standard Appeal would seriously jeopardize a Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard internal Appeal decision.

In these cases, We will make a decision no later than seventy-two (72) hours after the review commences. An Expedited Appeal is a request concerning an Admission, availability of care, continued stay, or healthcare service for a covered person who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility. Expedited Appeals are not provided for review of services previously rendered.

If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process and timeframe.

An Expedited Appeal shall be made available to, and may be initiated by, the covered person or an authorized representative, with the consent of the covered person's treating healthcare Provider, or the Provider acting on behalf of the covered person. Requests for an Expedited Internal Appeal may be oral or written and should be made to:

HMO Louisiana, Inc.
Expedited Appeal - Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022
1-800-376-7741 or 1-225-293-0625

d. Expedited External Medical Appeal

An Expedited External Review is a request for immediate review, by an Independent Review Organization (IRO) randomly assigned by the Louisiana Department of Insurance, of an initial Adverse Determination not to Authorize continued services for Members currently in the emergency room, under observation in a facility or receiving Inpatient care.

Expedited External Appeals are not provided for review of services previously rendered. An Expedited External Appeal of an adverse decision is available if pursuing the standard Appeal procedure could seriously jeopardize the Member's life, health or ability to regain maximum function; or when in the opinion of the treating physician, the Member may experience pain that cannot be adequately controlled while waiting for a decision on a second level standard Appeal.

An Expedited External Appeal is also available if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the covered person's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated. The request may be simultaneously filed with a request for an expedited internal review, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt.

We will forward all pertinent information to the IRO so the review is completed no later than seventy-two (72) hours of receipt. Any decision rendered by the IRO is binding on Us and the Member. This Appeals process shall constitute the Member's sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary, except to the extent that other remedies are available under State or Federal law.

D. Binding Nature of External Appeal Decisions

All external review decisions are binding on Us and You for purposes of determining coverage under a health Contract. This Appeals process shall constitute your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

E. Appeal Response Timeframes

In the case of a Claim involving Urgent Care as defined below, We will expedite the review process. The Member may request an expedited review orally or in writing. All necessary information may be transmitted between the parties by telephone, facsimile, or other available similarly expeditious means. We will review the Member's Appeal promptly. The Member will receive notice of Our review decision for:

1. Urgent Care Claims as soon as reasonably possible taking into account medical exigencies, but not later than seventy-two (72) hours after We receive the Member's request for an Appeal of an adverse Benefit determination. ("Urgent Care Claim" means any Claim with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (b) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.)
2. Pre-service Claims within a reasonable period of time appropriate to the medical circumstances but not later than thirty (30) days after We receive the Member's request for Appeal of an adverse Benefit determination. ("Pre-service Claim" means any Claim for a Benefit under the Plan with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval or Authorization of the Benefit in advance of obtaining care or treatment.)
3. Post-service Claims within a reasonable period of time, but not later than thirty (30) days after We receive the Member's request for Appeal of an adverse Benefit determination. ("Post-service Claim" means any Claim for a Benefit under the plan that is not an Urgent Care Claim or a Pre-service Claim as defined.)

We may extend the initial period for review of a post-service Claim by fifteen (15) days prior to the end of the initial thirty (30) day period if special circumstances require an extension of time. Any notice of extension will be in writing, explain the special circumstances that may dictate an extension of the time period needed to review the Member's Appeal and give the date by which We expect to make Our decision. In any event, however, the Member will receive written notice of Our decision no later than forty-five (45) days after the Member's request for review is received.

ARTICLE XIX. CARE WHILE TRAVELING, MAKING POLICY CHANGES AND FILING CLAIMS

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

All of the forms mentioned in this section can be obtained from one of Our local service offices or from the home office of HMO Louisiana, Inc. The Change of Status Card has the health questionnaire on the reverse side. This form should also be available through Your insurance agent. If You need to submit documentation to Us, You may forward it to Our home office at:

HMO Louisiana, Inc.
P.O. Box 98045
Baton Rouge, LA 70898-9045

or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809. If You have any questions about any of the information in this section, You may call Your insurance agent or Our Customer Service Department at the number on Your ID card.

OBTAINING CARE WHILE TRAVELING, MAKING POLICY CHANGES AND FILING CLAIMS

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

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

CHANGING FAMILY MEMBERS ON YOUR POLICY

The Schedule of Eligibility lets You know how to add additional family Members to Your policy. Please read the Schedule of Eligibility and this section as they contain important information for You.

A Change of Status Card is required to add newborn children, newborn adopted children, a Spouse, or other Dependents to coverage. We should receive Your completed form in Our home office within thirty (30) days of the child's birth or placement, or Your marriage. A Change of Status Card is also required to remove existing family Members from coverage.

If You do not complete and return a required Change of Status Card to Us within the timeframes set out in the Schedule of Eligibility, it is possible that Your insurance coverage will not be expanded to include the additional family Members. Completing and returning a Change of Status Card is especially important when Your first Dependent becomes eligible for coverage or when You no longer have any eligible Dependents.

HOW TO FILE INSURANCE CLAIMS FOR BENEFITS

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

HMO Louisiana, Inc.
P. O. Box 98024
Baton Rouge, LA 70898-9024

Your HMO Louisiana, Inc. ID card shows the way Your name appears on the Company records. (If You have Dependent coverage, the name(s) are recorded as You wrote them on Your application card.) The ID card also lists Your Contract number (ID #). This number is the identification to Your Membership records and should be provided to Us each time a Claim is filed. To assist in promptly handling Your Claims, please be sure that:

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

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

ADDITIONAL INFORMATION FOR FILING SPECIFIC CLAIMS

Admission to a Hospital or Allied Health Facility Claims

When You or an enrolled Member of Your family is being admitted to an HMOLA or Participating Provider, show Your HMO Louisiana, Inc. ID card to the admitting clerk. The Provider will file the Claim with Us. Our payments will go directly to the HMOLA or Participating Provider. The Provider will then bill You directly for any remaining balance. You will receive an Explanation of Benefits after the Claim has been processed.

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 Member. If this occurs, the Member 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 Subscriber. The Provider must mark the statement or claim form PAID. The Member should forward this statement to HMO Louisiana, Inc.

Emergency Room

When the Member or an enrolled Member of the Member's family has Emergency Room services performed by a Network or Non-Network Provider, the Member should show their HMOLA ID card to the admitting clerk. The Provider will file the claim with Us. Our payments will go directly to the Provider. The Member will receive an Explanation of Benefits after the claim has been processed.

Prescription Drug Claims

Most Members that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for Members who present an ID card to a Participating Pharmacist. However, if the Member must file a Claim to access their Prescription Drug Benefit, the Member must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The claim form should then be sent to HMO Louisiana, Inc.'s Pharmacy Benefit Manager, whose telephone number should be found on the Member's ID card. Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug.

Other Medical Claims

When You receive other medical services (clinics, Provider offices, etc.) You should ask if the Provider is an HMOLA or Participating Provider. If yes, this Provider will file Your Claim with Us. In some situations, the Provider may request payment and ask You to file. If this occurs, be sure the claim form is complete before forwarding to HMO Louisiana, Inc.

If You are filing the Claim, the Claim must contain the itemized charges for each procedure or service.

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

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

Claims for Nursing Services

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

Claims for Durable Medical Equipment (DME)

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

IF YOU HAVE A QUESTION ABOUT YOUR CLAIM

If You have a question about the processing or payment of a Claim, You can write Us at the address below or You may call Our Customer Service Department at the number on Your ID card or any of Our Local Service Offices.* If You call for information about a Claim, We can help You better if You have the information at hand; particularly the Contract number, patient's name and date of service.

Remember, ALWAYS refer to Your Contract number in all correspondence and recheck it against the Contract number on Your ID card to be sure it is correct.

HMO Louisiana, Inc.
P. O. Box 98024
Baton Rouge, LA 70898-9024

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

LLHIGA NOTICE

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

- A. Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association, or LLHIGA. The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage. Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer. The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA

P.O. Drawer 44126
Baton Rouge, Louisiana 70804

Department of Insurance

P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

- B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S.22:2081 et seq. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.
- C. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state; unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.
- D. Exclusion from Coverage
1. A person who holds a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:
 - a. he is eligible for protection under the laws of another state;
 - b. the insurer was not authorized to do business in this state;
 - c. his policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined by law, or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

- a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- b. any policy of reinsurance (unless an assumption certificate was issued);
- c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- d. dividends, premium refunds, or similar fees or allowances described under the law;
- e. credits given in connection with the administration of a policy by a group contract holder;
- f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
- g. unallocated annuity contracts (which give rights to group contract holders, not individuals), except if qualified by law
- h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
- i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
- j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

E. Limits on Amounts of Coverage

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.
2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:
 - a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
 - b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
 - c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$500,000 in health insurance benefits, and LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.
3. In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any one individual.



Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (audio, accessible electronic formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@bcbsla.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238 or 1-800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Or

Electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨打 1-800-711-5519 (TTY 711)。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك. إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານພຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرید.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)

