NGF INDIVIDUAL

BLUE Connect

INDIVIDUAL HMO POINT OF SERVICE CONTRACT

Para solicitar una versión en español de este Plan de beneficios, por favor llame a nuestro Departamento de Servicio al Cliente al número de teléfono en su tarjeta de identificación.

Louisiana

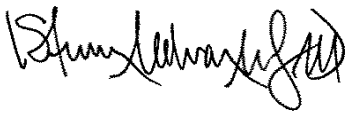
19636EX-024 R01/23

HMO Louisiana

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 the ID card and we will do our best to assist you.

My best to you,



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

Louisiana HMO Louisiana

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) 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 mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed or reconstruction of both breasts if a bilateral mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomy, 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 Deductible Amount, Coinsurance, and Copayments applicable to other medical and surgical Benefits provided under this plan. Information on the plan's specific Deductible Amount, Coinsurance, or Copayment will be shown on the Schedule of Benefits.

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 the ID card.

BLUE CONNECT NETWORK HMO POINT OF SERVICE

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 You pay the premiums according to the Contract requirements and do not violate any provisions, You may renew this Contract if You choose.

If You decide that You do not want this Contract; You may return it within 10 days after You receive it and We will refund Your fees.

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, DEDUCTIBLE AMOUNTS, 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 THE ID CARD.

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.

We base Our payment of Benefits for the Member's Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom a Member receives Covered Services.

Note that federal law prohibits a Non-Network Provider from balance billing a Member for non-Emergency Medical Services performed at a Network facility unless the Provider issued the required written notice to a Member and has obtained a Member's Informed Consent to provide such services.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. The 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.

Breast reconstruction is covered for a Member who due to breast cancer obtains a partial mastectomy or a full unilateral or bilateral mastectomy as selected by the Member in consultation with the attending Physician(s). The services under this Benefit are subject to any Copayment, Deductible Amount and Coinsurance.

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 Copayments, Deductible Amounts and Coinsurances.

We will send any important information about this Contract to the mailing address You gave Us on the Application for Individual Coverage. **You must tell Us if You change Your address of record.**

Requirement To Select A Primary Care Physician (PCP)

This coverage requires You to designate a Primary Care Physician (PCP). You have the right to designate any PCP 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 PCP. For information on how to select a PCP, and for a list of the PCP in Your Network, visit **www.bcbsla.com** or call the customer service phone number on the ID card. Additional information about Your PCP selection can be found in the What Are the Basics About Your Coverage Article of this contract.

You do not need prior Authorization from Us or from any other person (including a PCP) in order to obtain direct 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 the ID card.

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. Drugs that are not listed on the formulary, also called non-formulary drugs are not covered. 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 in several ways. Most Members receive information from Us by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy**.

You may also call Us at the number on the 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 it 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 formulary exception process. This process allows You, Your designee or Your prescribing healthcare Provider to ask for a formulary exception 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 request is not approved, You may file an internal or external formulary exception request to Us.

Notice of Continuation of Prescription Drug Coverage

You have the right to continue the coverage of any Prescription Drug that We approved or covered 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 Contract and is medically appropriate for You.

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

HMO Louisiana, Inc. issues this health Contract to the Subscriber shown on the Schedule of Benefits. As of the Effective Date or amended Effective Date shown on the Schedule of Benefits, We agree to provide the Benefits specified in this Contract for Subscribers and their enrolled Dependents. This Contract replaces any others previously issued to the Subscriber, as of the amended Effective Date. This Contract describes Member Benefits, as well as Member rights and responsibilities under this coverage. We encourage You to read this Contract carefully.

You should call Us if You have questions about Your coverage, or any limits to the coverage available to You. 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. 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.

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 enrolled Dependent. Capitalized words are defined terms in the Definitions Article of this Contract. A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

A. This Coverage and the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (the Affordable Care Act) were signed into law in March, 2010. This coverage is compliant with and subject to the Affordable Care Act and covers all Essential Health Benefits required by law.

Coverage under the Affordable Care Act can be purchased either through:

1. the Exchange, with or without the assistance of an agent or producer; or

2. HMO Louisiana, Inc. directly or through an agent or producer.

The Exchange is the health insurance marketplace that is operated by the federal government for the State of Louisiana. Coverage purchased through the Exchange is called On-Exchange coverage. Coverage purchased directly from Us or from an agent or producer is called Off-Exchange coverage.

Several important parts and provisions of this Contract are different based on whether this coverage was purchased On- Exchange or Off-Exchange. See the Schedule of Benefits to determine if Your coverage is On-Exchange or Off-Exchange coverage so You will know which Contract language applies to You.

B. Facts About this HMO Blue Connect Network Point of Service Contract

This is a point of service Contract. You have comprehensive medical and drug coverage, but have a restricted Network of Providers available to You – the Blue Connect Network. You can get care from Providers who are not in Your Blue Connect Network, but Benefits will be paid at a lower level.

A Tier 1 Provider is a Blue Connect Network Provider. You get the best benefits and pay the least when you go to a Provider in the Blue Connect Network. **Always get your services performed by a Tier 1 Provider if at all possible.**

A Tier 2 Provider is a Participating Provider - not in the Blue Connect Network - that has signed a Provider agreement to participate in other Networks of HMOLA, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan**. If you cannot go to a Tier 1 Provider, you should do your best to go to a Tier 2 Provider.** You will pay more than a Tier 1 Provider, but will receive significant cost protections that are available only when you see a Tier 1 or Tier 2 Provider.

A Tier 3 Provider is a Non-Participating Provider or a Provider who is not in the Blue Connect Network and who has not signed a Provider agreement to participate in the HMOLA Network or any Blue Cross and Blue Shield plan. There are also Providers that are in other Networks that have specifically chosen not to be in either Tier 1 or Tier 2 Networks. These Providers may be indicated in the Blue Connect Network directory to help you select the lower cost Providers.

Tier 3 Providers will cost you the highest cost share and will not protect you from significant costs for their services. Avoid Tier 3 Providers if there is any way to get services from Providers in the other tiers.

If You go to Providers in Your Blue Connect Network, You will pay the least for care and get the most value from this Contract. You may choose which Providers will render Your care. This choice will determine the amount We pay and the amount the You pay for Covered Services.

For example, if a Copayment is shown on the Schedule of Benefits, You must pay the Copayment to the Network Provider each time You receive the Covered Services listed. Most Benefits are subject to Your payment of a Deductible Amount. After payment of Deductible Amount, Benefits are subject to two Coinsurances (for example, 80/20, 60/40). Your choice of a Provider determines what Coinsurance applies to the service provided. We will pay the highest Coinsurance for Medically Necessary services when You go to a Provider in the Blue Connect Network. We will pay the lower Coinsurance when You receive Medically Necessary services from a Provider who is not in the Blue Connect Network. Deductible Amounts and Coinsurance are stated on the Schedule of Benefits.

This is a direct access plan. You may see Specialists in the Blue Connect Network without contacting a Primary Care Physician (PCP) or getting a referral from a PCP.

This Contract provides Benefits when You travel. If You cannot see a Provider in the Blue Connect Network, try to see a Provider in a Blue Cross Network. This will allow You to receive the best value under the Contract. When You travel outside the state of Louisiana and need to find a Provider, call the BlueCard® number on the ID card.

C. Our Blue Connect Provider Network

You choose which Providers will give You care. This choice will determine the amount We pay and the amount You pay for Covered Services.

HMO Louisiana, Inc. has put together a restricted Provider Network for this Contract, consisting of a select group

of Physicians, Hospitals and other Allied Providers. We call these Providers Blue Connect Network Providers or Network Providers. Oral Surgery Benefits are also available when given by Providers in the United Concordia Dental Advantage Plus Network or in the Blue Cross and Blue Shield of Louisiana's dental Network.

Network Benefits mean the highest level of Benefits payable under this Contract when You go to Providers in the Blue Connect Network. Non-Network Benefits mean a lower level of Benefit if You go outside the Blue Connect Network for care. To receive Blue Connect Network Benefits, always verify that a Provider is a current Blue Connect Network Provider. Visit Our website at **www.bcbsla.com**, or call customer service at the number on the ID card to verify that a Provider is a current Blue Connect Network Provider, or to request a paper Provider directory. Our Blue Connect 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 giving services from another location. Always check the Provider directory to verify that the services are in the Blue Connect Network at the location where You are seeking care.

Additionally, Providers in the Blue Connect Network may be contracted to perform certain Covered Services but may not be contracted in the Blue Connect Network to perform other Covered Services. When a Blue Connect Network Provider performs services that the Blue Connect 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. Check Your Provider directory to verify that the services are In-Network when performed by the Provider or at the Provider's location.

We pay a lower level of Benefits when You go to a Provider outside the Blue Connect Network. Benefits may also be based on a lower Allowable Charge. You will usually pay Deductible Amount and Coinsurance instead of a Copayment. Receiving care from a Non-Network Provider will result in higher costs to You. A daily penalty may apply when Inpatient care is received from a Non-Network Hospital. We recommend that You ask Non-Network Physicians or healthcare professionals about their billed charges before You receive care. Review the Sample Illustration of Your Costs When You Go to a Non-Participating Hospital before receiving care outside the Network.

To the extent required by applicable law, Your cost sharing for Emergency Medical Services will be at the Network level even if the Hospital is not in Your Network.

D. United Concordia Dental Advantage Plus Network

This Contract covers Pediatric Dental Care Benefits for Members under age nineteen (19). United Concordia Companies, Inc. doing business as United Concordia Dental (UCD) is HMO Louisiana, Inc.'s Network and claims administrator for the dental Benefits and is in charge of managing the Advantage Plus Network, handling and paying Claims, and providing customer services to the Members eligible to receive these Benefits.

United Concordia Dental Advantage Plus Network consists of a select group of Providers who have contracted with United Concordia Dental to give services to Members for reduced amounts. All other Providers are considered Non-Participating. Non-Participating Providers may bill You more for their services than Participating Providers.

To receive full pediatric dental Benefits, You should verify that a Provider is an Advantage Plus Network Participating Provider before any service is given. To find a Participating Provider and verify their continued participation in the Advantage Plus Network, or to ask any questions about Benefits or Claims, visit **www.bcbsla.com** or call customer service at (866) 445-5338.

We, Us, and Our mean United Concordia Dental when it acts on behalf of HMO Louisiana, Inc. in performing its services under the dental coverage provided in the Articles for Oral Surgery Benefits and Pediatric Dental Care Benefits.

We will base reimbursements for services given by a Non-Participating Provider on Our Allowable Charge and will pay them in the same amounts, under the same limits, rules and policies that We would have applied to Claims for services given by a Participating Provider. Care received from a Non-Participating Provider will mean a higher cost to You. We recommend that You ask the Non-Participating Provider about their billed charges before You receive care.

E. Davis Vision Network

Davis Vision, Inc. (Davis Vision) is Our Network and claims administrator for the vision Benefits provided, and manages the Davis Vision Network, handles and pays Claims, and provides customer services to the Members under age 19 eligible to receive these Benefits.

The Davis Vision Network consists of a select group of Providers who have contracted with Davis Vision to give services and supplies to You for minimal costs. We consider all other Providers to be Non-Participating.

To receive the full Benefits under this section, verify that a Provider is a Davis Vision Network Participating Provider before any service is given. To find a Participating Provider and verify their continued participation in the Davis Vision Network, or to ask any questions about Benefits or Claims, visit **www.davisvision.com** or call customer service at 1-800-247-9368.

F. Obtaining Care Outside Louisiana and Around the World

Members have access to Emergency and non-Emergency care outside Louisiana and around the world. Your ID card offers convenient access to Covered Services through Blue Cross and Blue Shield Providers throughout the United States and in more than 200 countries worldwide.

In the United States:

Emergencies**:** To the extent required by applicable law, Members receive Network Benefits when covered Emergency Medical Services are provided by Providers that are not in Your Network.

Non-Emergencies**:** Members receive Non-Network Benefits when covered non-Emergency Medical Services are given outside Your Service Area. Because no Blue Connect Network Service Area exists outside Louisiana, Covered Services given outside Louisiana are paid at the Non-Network Benefit level. If You obtain these services

from a BlueCard® Provider, You may only have to pay Your Network amount since BlueCard® Providers will generally accept the Allowable Charge as payment in full for the service.

Outside the United States:

Emergencies**:** To the extent required by applicable law, Members receive Network Benefits when covered Emergency Medical Services are provided by Providers that are not in Your Network.

Non-Emergencies**:** Members receive Non-Network Benefits when covered non-Emergency Medical Services are given outside Your Service Area. Because no Blue Connect Network Service Area exists outside the United States, Covered Services given outside the country are paid at the Non-Network Benefit level. If You obtain these services from a Blue Cross Blue Shield Global® Core Provider, You may only have to pay Your Network amount since Blue Cross Blue Shield Global® Core Providers will generally accept the Allowable Charge as payment in full for the service.

How to Get Care Outside the Service Area:

1. In an Emergency, go directly to the nearest Hospital.

2. Call BlueCard® Access at 1-800-810-BLUE (1-800-810-2583) for information on the nearest BlueCard® Nationwide doctors and Hospitals (for care in the United States), or for information on Blue Cross Blue Shield Global® Core doctors and Hospitals (for care outside the United States). Provider information is also available at **www.bcbs.com**.

3. Use a BlueCard® Nationwide or Blue Cross Blue Shield Global® Core Provider.

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.

G. Selecting a Primary Care Physician (PCP) for Contracts with an office visit Copayment

When You enroll with Blue Connect it is **a requirement of this Contract for you** to choose a Primary Care Physician (PCP). PCPs are family practitioners, general practitioners, internists, geriatricians, or pediatricians. Each member of the family may use a different PCP. PCPs may coordinate healthcare needs from Consultation to hospitalization, direct a Member to an appropriate Provider when necessary, and help assist in obtaining any required Authorizations.

A PCP serves as Your total care coordinator for non-emergent care. PCPs, when unavailable to you, will have arrangements in place to provide their patients with information on how to get care after regular office hours. In rare cases, if You have not selected a PCP and we cannot verify Your choice, a PCP may be assigned. You may select a different PCP by contacting Our customer service department.

H. Using a Primary Care Physician (PCP)

This Contract is sold with or without an office visit Copayment. The Schedule of Benefits will state whether a Copayment applies. If a Copayment for office visits is shown on the Schedule of Benefits, this direct access plan allows You to receive care from a Primary Care Physician (PCP) or from a Specialist. No PCP referral is required prior to accessing care directly from a Specialist in the Blue Connect Network.

Members pay the lowest 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 may coordinate healthcare needs from Consultation to hospitalization, direct a Member to an appropriate Provider when necessary, and assist in obtaining any required Authorizations.

The office visit Copayment may be reduced when services are rendered by a Provider participating in the Quality Blue program. Quality Blue Providers include family practitioners, general practitioners, pediatricians, internists, geriatricians, nurse practitioners and physician assistants but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, You may review a Provider

directory on Our website at **www.bcbsla.com** or contact Our customer service department at the number on the ID card.

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

I. Authorizations

Some services and supplies require Authorization from Us before 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.

Blue Connect Network Providers are required to obtain necessary Authorizations on Your behalf. When a Blue Connect Network Provider does not obtain a required Authorization, We penalize the Blue Connect Network Provider, not You, as described on the Schedule of Benefits. You pay only for the Blue Connect Network Copayment, Deductible Amount, and Coinsurance shown on the Schedule of Benefits.

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

If a Blue Connect Network Provider directs or refers You to another Provider, You must make sure that the new Provider is in the Blue Connect Network, if You want to receive Blue Connect Network Benefits.

No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless We Authorize these services. The services must be given either by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or by a transplant facility in Our HMOLA Network, unless We otherwise approve it in writing. To find an approved transplant facility, call customer service at the number on the ID card.

J. How We Determine What We Pay for the Member's Covered Services

When the Member uses Blue Connect Network Providers (Tier 1)

Blue Connect Network Providers have signed a contract with Us to participate in the Blue Connect Provider Network. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. This amount is the Blue Connect Network Provider's Allowable Charge and is used to determine the amount We pay for Medically Necessary Covered Services. Members who use Blue Connect Network Providers will receive Blue Connect Network Benefits and will pay the amounts shown in the Blue Connect Network column on the Schedule of Benefits for these services.

When the Member uses Participating Providers (Tier 2)

Participating Providers have not signed a contract with the Blue Connect Network, but have signed contracts with the HMOLA Network, Blue Cross and Blue Shield of Louisiana or any other Blue Cross and Blue Shield plan 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. This amount is the Participating Provider's Allowable Charge and it is used to determine the amount that We pay for Medically Necessary Covered Services.

Members who use a Participating Provider will pay more for Medically Necessary Covered Services than if a Blue Connect Network Provider was used. This will result in higher costs to the Member as shown in the Participating column on the Schedule of Benefits. However, the Member will be protected from paying the difference between the Allowable Charge and the Provider's billed charge.

The Member has the right to file an Appeal with Us for consideration of Network Benefits if the Member 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.

When the Member uses Non-Participating Providers (Tier 3)

Non-Participating Providers do not have a contract with the Blue Connect Network, HMOLA Network, with Blue Cross and Blue Shield of Louisiana, or any another Blue Cross and Blue Shield plans. 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 one of the following as determined by Us:

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.

Members usually 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, Blue Connect Network Providers and Participating Providers waive the difference between the actual billed charge for Covered Services and the Allowable Charge, while Non-Participating Providers do not.

The Member has the right to file an Appeal with Us for consideration of Network 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 the Member's home. To file an Appeal, the Member must follow the Appeal procedures in this Contract.

Note that federal law prohibits a Non-Network Provider from balance billing a Member for non-Emergency Medical Services performed at a Network facility unless the Provider issued the required written notice to a Member and has obtained a Member's Informed Consent to provide such services.

Sample Illustration of Member Costs When Care Is Obtained at a Non-Participating Hospital

Note: The following example is for illustration purposes only and is not a true reflection of the Member's actual Copayments, Deductible Amount, and Coinsurances. Please refer to the Schedule of Benefits to determine Your Benefits.

Example: The Network Benefits are 80% - 20% Coinsurance with a Deductible Amount. The Non-Network Benefits are 60% - 40% Coinsurance with a Deductible Amount. Assume the Member goes to the Hospital, has already met the Deductible Amount, and has obtained the necessary Authorization prior to receiving a non-Emergency service. The Hospital bills $12,000 for the Covered Service. We negotiated an Allowable Charge of $2,500 with the Network Hospital to render this service. The Allowable Charge of the Participating Hospital is $3,000 to render this service. There is no negotiated rate with the Non-Participating Hospital. The Member is responsible for all amounts not paid by the Company, up to the Hospital's billed charge. This example illustrates the Member's costs at three different hospitals for the same service.

The Member receives Covered Services from:	**Network Hospital**	**Participating Hospital**	**Non-Participating Hospital**
Hospital 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	**$1,800** $3,000 Allowable Charge x 60% Coinsurance **= $1,800**	**$1,500** $2,500 Allowable Charge x 60% Coinsurance **= $1,500**
Member pays:	**$500** 20% Coinsurance x $2,500 Allowable Charge **= $500**	**$1,200** 40% Coinsurance x $3,000 Allowable Charge **= $1,200**	**$1,000** 40% Coinsurance X $2,500 Allowable Charge **= $1,000**
Is Member billed up to the Hospital's billed charge?	NO	NO	YES - $9,500
TOTAL AMOUNT MEMBER PAYS:	**$500**	**$1,200**	**$10,500**

K. Prescription Drug Benefits

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 Network Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount We Pay Our Pharmacy Benefit Manager to base Our payment for Your covered Prescription Drugs and the amount that You must pay for covered Prescription Drugs.

When You buy covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when You file a paper Claim with Us or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that We pay Our Pharmacy Benefit Manager for covered Prescription Drugs.

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

L. Mental Health or Substance Use Disorders

We have contracted with an outside company to perform certain administrative services related to Mental Health and substance use disorder services for Our Members. For help with these Benefits, see Your Schedule of Benefits, Your ID card, or call customer service.

M. 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.

N. 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.

O. Customer Service Email Address

HMO Louisiana, Inc. has consolidated Our customer service emails 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, email, postal mail and walk-in customer service. Just visit **www.bcbsla.com** and click on *Need Help?* to access our Help Center which includes Our customer service contact information.

P. Identity Protection Services

HMO Louisiana, Inc. is committed to protecting Your identity. This includes protecting the safety and security of Your information. To support Our efforts, We offer optional Identity Protection Services. If You elect to have Identity Protection Services, 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; and
3. fraud resolution support that assists Members in addressing issues that arise in relation to credit monitoring and fraud detection.

A Member is no longer eligible for these services if health coverage is terminated during the Contract Year. In this event, Identity Protection Services will terminate at the end of the Contract Year.

For information about Identity Protection Services, visit **www.bcbsla.com** or call customer service at the number on the ID card.

ARTICLE II. DEFINITIONS

Accidental Injury – A condition that directly results from a traumatic bodily injury sustained only through accidental means from an external force. Injuries caused by chewing are not injuries to teeth.

Admission – The period for Inpatient care from entry (Admission) into a Hospital or Skilled Nursing Facility or Unit until discharge. We count the date of entry and the date of discharge as one (1) day.

Adverse Benefit Determination – Means denial or partial denial of a Benefit based on:

A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment that is determined to be experimental or Investigational;

B. the Member's eligibility for coverage under the Contract;

C. any prospective or retrospective review determination;

D. a Rescission; or

E. a decision involving items and services within the scope of the surprise billing and cost-sharing protection requirements of the No Surprises Act.

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, or approved by Us to give Covered Services. For this Contract, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, Certified Midwives, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, physician assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as state law mandates for specified services, if We approve them to give 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 that this Contract does not routinely cover but may provide by agreement through Case Management.

Ambulance Service – Transportation by a specially designed Emergency vehicle that is used only when Medically Necessary to transport sick and injured people. The vehicle must be equipped as an Emergency transport vehicle and trained ambulance personnel must staff it according to appropriate state and local laws.

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of Physicians. This type of center has permanent facilities that are equipped and operated mainly to perform surgical procedures. A center has continuous Physician and registered professional nursing services available whenever

patients are in the facility, does not provide services or other accommodations for patients to stay overnight, and offers the following services whenever patients are in the center:

A. anesthesia services as needed for medical operations and procedures performed;

B. provisions for patients' physical and emotional well-being;

C. provision for Emergency Medical Services;

D. organized administrative structure; and

E. administrative, statistical, and medical records.

Appeal – A written request from a Member or a Member's authorized representative to change an Adverse Benefit Determination made by Us.

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

Authorization (Authorized) – Based on the information provided, Our decision that an Admission, continued Hospital stay, or other healthcare service or supply is Medically Necessary, in an appropriate healthcare setting, or at a necessary level of care and effectiveness. An Authorization does not guarantee payment. Also, an Authorization is not a determination about the Member's choice of Provider.

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

Bed, Board and General Nursing Service – Room accommodations, meals and all general services and activities that Hospital employees provide to care for patients. This service 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 Member, or by the terms of this 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 covered 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 someone to identify bone mass or detect 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 – A method of delivering patient care that emphasizes quality patient outcomes with efficient and cost-effective care. The process systematically identifies high-risk patients and assesses opportunities to coordinate and manage their total care to ensure the best health outcomes. Medical professionals provide these services and they focus on unusually complex, difficult, or catastrophic illnesses. We choose when to offer Case Management services to Members. Working with Your Physicians and with Your consent or the consent of Your family or caregiver, Our 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 – Diagnosing conditions associated with the functional integrity of the spine and treating those conditions by adjusting, manipulating, and using 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 to correct interference with normal nerve transmission and expression.

Claim – Written or electronic proof — in a form We accept — of charges for Covered Services that You receive when You are insured under this Contract. The provisions that are in effect when You receive the service or treatment will govern how We process any Claim.

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 – A share of the costs for services that this Contract covers. This amount is calculated as a percentage that We pay and a percentage that You pay. (For example, We pay 80% for a service and You pay 20%.) After You pay any Deductible Amount, We apply Your percentage to the Allowable Charges to figure how much You pay. We apply Our percentage to the Allowable Charges to determine Your Benefit.

Company – HMO Louisiana, Inc. (HMOLA)

Complaint – An oral expression of dissatisfaction with a service.

Complication(s) – A medical condition, arising from an adverse event or consequence, which requires services, treatment or therapy and which is determined by Us, 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 that a Physician who is not the attending Physician gives:

A. for a condition that is not related to the primary diagnosis, or

B. because the patient's condition is medically complex and requires more 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 about Your evaluation or treatment which is given after the attending Physician asks for it. Consultations do not include the following:

A. those that Hospital rules and regulations require,

B. anesthesia consultations,

C. routine consultations for clearance for Surgery, or

D. those between colleagues who share medical opinions as a matter of courtesy and normally without charge.

Contract – This agreement, including the Application for Individual Health Coverage, Schedule of Benefits, amendments, and any endorsements that entitle the Subscriber and any Dependents to Benefits.

Contract Date – The date on which We issued this Contract to You.

Contract Year – The 12-month calendar year beginning at 12:00 a.m. on January 1 and ending at 11:59 p.m. on December 31.

Controlled Dangerous Substances – A drug, 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 You must pay when You receive Covered Services. For that dollar amount, see the Schedule of Benefits. Your Network Provider may collect the Copayment directly from You.

Cosmetic Surgery – Any operative procedure, treatment, or service, or any portion of an operative procedure, treatment, or service that is performed primarily to improve physical appearance. An operative procedure, treatment, or service is not considered Cosmetic Surgery if it restores bodily function or corrects deformity to restore function of a part of the body that an Accidental Injury, disease, disorder or covered Surgery has altered.

Covered Service –Services or supplies specified in this Contract for which You may receive Benefits if a Provider gives them.

Creditable Coverage for HIPAA Portability – Coverage You had before any individual or group health plan including Medicare, Medicaid, government plans, church plans, COBRA and military plans or state children's health insurance program (for example, LaCHIP). Creditable Coverage does not include the following:

A. Specific disease policies (such as cancer policies);

B. Supplemental coverage (such as Medicare supplement);

C. Limited Benefits (such as accident only, disability insurance, liability insurance, workers' compensation, automobile medical payment insurance, credit only insurance); or

D. Coverage for onsite 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 given safely and reasonably by someone who is not medically skilled, or that are designed mainly to help patients with daily living activities. These activities include, but are not limited to:

A. Providing personal care; homemaking; moving the patient;

B. Acting as companion or sitter;

C. Supervising medication that can usually be self-administered;

D. Treating or providing services that anyone may be able to perform with minimal instruction; or

E. Providing long-term treatment for a condition of a patient who is not expected to improve or recover.

We determine which services are Custodial Care.

Day Rehabilitation Program – A program that provides more than one (1) hour of Rehabilitative Care after someone is discharged from an Inpatient Admission.

Deductible Amounts –

A. Individual Deductible Amount –

   1. The dollar amount, as shown on the Schedule of Benefits, of Allowable Charges for Covered Services that a Member must pay within a Benefit Period before the Benefit Plan starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown as applicable on the Schedule of Benefits.

   2. Network and Non-Network Benefit categories may each carry a separate Individual Deductible Amount as shown on the Schedule of Benefits.

B. Family Deductible Amount - The dollar amount, if shown on the Schedule of Benefits, for each category of Benefits to which a Deductible Amount applies. Once a family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all members of the family, regardless of whether each individual has met his Individual Deductible Amount.

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. 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. Dentistry is the 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, 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 replacing 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, 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 - whom We have accepted for coverage as shown in the Schedule of Eligibility.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures We recognize as accepted medical practice, which are given because of specific symptoms and which are directed toward detecting or monitoring a definite condition, illness, or injury. A Provider must order a Diagnostic Service before delivering it.

Durable Medical Equipment – Items and supplies used to serve a specific therapeutic in treating an illness or injury. They can withstand repeated use; are generally not useful to someone who is not ill, injured, or diseased; and are appropriate to use in the patient's home.

Effective Date – The date Your coverage begins under this Contract. Benefits will begin at 12:01 AM on this date. See the Schedule of Eligibility.

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

Emergency – See Emergency Medical Condition.

Emergency Admission – An Inpatient Admission to a Hospital that results 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 who acts reasonably and possesses an average knowledge of health and medicine to believe that not receiving immediate medical attention could reasonably be expected to result in:

A. Seriously jeopardizing the health of the person, or if a woman is pregnant, the health of the woman or her unborn child;

B. Seriously impairing bodily function; or

C. Causing serious dysfunction of any bodily organ or part.

Emergency Medical Services –

The following when related to an Emergency Medical Condition, unless not required by applicable law:

A. When within the capability of a Hospital or independent freestanding Emergency department, the following services and items:

    1. A medical screening examination, including ancillary services routinely available to the Emergency department to evaluate an Emergency Medical Condition.

    2. Further medical examination and such treatment as may be required to stabilize the medical condition, regardless of the department of the Hospital in which such further examination or treatment is furnished.

B. With respect to an Emergency Medical Condition and regardless of the department of the Hospital where furnished, additional services that are:

    1. Covered Services under the Contract;

    2. Furnished after the Member is stabilized; and

    3. Part of an Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Medical Services are furnished.

If certain conditions set forth in applicable law are met, the additional services listed above are not deemed to be Emergency Medical Services and are not required to be covered as Emergency Medical Services.

Essential Health Benefits – Benefits required to be covered by this plan under the Patient Protection and Affordable Care Act, which include at least the following ten (10) general categories:

A. Ambulatory patient services;

B. Emergency Medical Services;

C. Hospitalization;

D. Maternity and newborn care;

E. Mental Health and substance use disorder services, including behavioral health treatment;

F. Prescription Drugs;

G. Rehabilitative and Habilitative services and devices;

H. Laboratory services;

I. Preventive or Wellness Care services and chronic disease management;

J. Pediatric services, including oral and vision care.

Exchange – The health insurance marketplace that the federal government operates for the State of Louisiana under Section 1311 of the Patient Protection and Affordable Care Act.

Expedited Appeal – A request for immediate internal review of an Adverse Determination, which involves any of the following situations:

A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function.

B. In the opinion of the treating Physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

C. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization, of an Adverse Benefit 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.

B. A decision to not Authorize an Admission, availability of care, continued Hospital stay or healthcare service for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

C. A denial of coverage based on a determination that 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, or the immediate and serious deterioration of the health of the Member.

External Appeal – A request for review by an Independent Review Organization to change an initial Adverse Benefit Determination made by the Company or to change a final Adverse Benefit Determination rendered on Appeal. An External Appeal is available upon request by the Member or the Member's authorized representative for Adverse Benefit Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, Rescission, or for Claims for which external review is provided under the No Surprises Act.

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. Based on a nationally recognized pricing source, We classify Prescription Drugs as Generic Drugs. Manufacturers or pharmacies do not classify them for Us. We may not classify the same drugs as Generic Drugs that manufacturers or pharmacies do.

Gestational Carrier – A woman not covered on the Contract 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.

Habilitative Care – Health care services and devices that help patients keep, learn, or improve their skills and functioning for daily living. These services may include Physical Therapy, Occupational Therapy, Speech/Language Pathology Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation and other services for people with disabilities in a variety of inpatient or outpatient settings.

Home Health Care – Health services given in someone's home by an organization that We approve and that the appropriate state agency licenses as a Home Health Care agency. At the written direction of a licensed Physician, these organizations primarily provide skilled nursing services by or under the supervision of a Registered Nurse (RN) licensed to practice in the state.

Hospice Care – 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. A Physician directs an interdisciplinary team that centrally coordinates the full scope of health services. A Hospice Care agency that We approve provides the services and supplies.

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

Imaging Services –

A. Low-Tech Imaging – Imaging Services which include, but are not limited to, x-rays, machine tests, diagnostic imaging, and radiation therapy.

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

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 entity, not affiliated with Us, that conducts external reviews of Adverse Benefit Determinations, Rescission determinations and No Surprises Act-related decisions. The decision of the IRO is binding on both Members and Us, except to the extent that other remedies are available under state or federal law.

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

Informal Reconsideration – A telephone request that We review a Utilization Management decision not to Authorize a service or treatment. You may ask for an Informal Reconsideration within 10 days after an initial or Concurrent Review determination.

Informed Consent – A written document provided along with a written notice to a Member by a Non-Network Provider that must be executed by a Member in order for a Non-Network Provider to obtain the Member's consent to receive medical treatment and services from the Non-Network Provider without the protections provided by the No Surprises Act.

Inpatient – A Member who is admitted to a Hospital as 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 a Physician or nurse to intervene continuously, 24 hours a day. If the services can be safely provided as an Outpatient, You do not meet the criteria for an Inpatient.

Intensive Outpatient Programs –Programs that can provide for planned, structured, service for at least two (2) hours per day and three (3) days per week, although some patients may need to attend less often. These encounters usually comprise coordinated and integrated multidisciplinary services. The range of services address a mental or a substance-related disorder and could include group, individual, family, or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment, rehabilitation, and counseling visits or professional supervision and support. Program models include structured crisis intervention programs, psychiatric or psychosocial rehabilitation, and some day treatment. (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here does not include times spent in these self-help programs, which community volunteers offer without charge).

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

    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.

Medically Necessary (or Medical Necessity) – Healthcare services, treatment, procedures, equipment, drugs, devices, items, or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms, and that are:

A. According to 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 their sequence and that are as likely to produce equivalent therapeutic or diagnostic results for diagnosing or treating 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 who is enrolled in this Contract. We may use common words in this Contract to describe the Benefits it provides. You, Your, and Yourself mean the Subscriber or enrolled Dependent.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes:

A. psychoses,

B. neurotic disorders,

C. personality disorders,

D. affective disorders,

E. the following specific severe mental illnesses defined by La. R.S. 22:1043

F. schizophrenia or schizoaffective disorder;

G. bipolar disorder;

H. panic disorder;

I. obsessive-compulsive disorder;

J. major depressive disorder;

K. anorexia and bulimia;

L. intermittent explosive disorder;

M. post-traumatic stress disorder;

N. psychosis NOS when diagnosed in a child under seventeen (17) years of age;

O. Rett's Disorder;

P. Tourette's Disorder;

Q. 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 that We determine.

The definition of Mental Disorder will be the basis for determining Benefits, despite whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Network Benefits – Benefits for care You receive from a Blue Connect Network Provider. We also call Network Benefits In-Network.

Network Pharmacy – Pharmacies that have signed a Contract with Us or Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for covered Prescription Drugs they dispense to You. Network Pharmacies may also be referred to as Participating Pharmacies.

Network Provider – A Provider who has signed an agreement with Us to participate as a member of the HMO Louisiana, Inc. Blue Connect Provider Network. We also call this Provider a Blue Connect Network Provider or In-Network Provider.

Newly Born Infant – Infants from birth until 1 month old or until they are well enough to be discharged to home from a Hospital or neonatal Special Care Unit, whichever period is longer.

Non-Network Benefits – Benefits for care You receive from Providers who are not in the Blue Connect Network. We also call Non-Network Benefits Out-of-Network.

Non-Network Provider – A Provider who is not a member of the HMO Louisiana, Inc. Blue Connect Provider Network. Participating Providers and Non-Participating Providers are Non-Network Providers because they have not contracted with the HMOLA Blue Connect Provider Network. We also call Non-Network Providers Non-Blue Connect Network Providers.

No Surprises Act (NSA) – A portion of the Consolidated Appropriations Act, 2021 (Public Law 116-260) enacted on December 27, 2020, that establishes patient rights and protections from surprise billing and limits cost sharing under many of the circumstances in which surprise billing occurs most frequently.

Occupational Therapy – Evaluating and treating 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 other interventions that alleviate impairment or improve functional performance. These can include: designing, fabricating, or applying Orthotic Devices; training in using Orthotic Devices and Prosthetic Devices; designing, developing, adapting, or training in use of assistive devices; and adapting environments to enhance functional performance.

Open Enrollment Period – Designated by the federal government, a period of time each year during which a Subscriber and any eligible Dependents may enroll for coverage under this Contract. Federal law requires that the Open Enrollment Period be 30 days or longer.

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

Out-of-Pocket Amount – The highest amount of unreimbursable expenses that a Member must pay for Covered Services in one (1) Benefit Period. For the specific dollar amount, see the Schedule of Benefits.

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

Over-Age Dependent - A Dependent child (or grandchild) who is age twenty-six (26) or older, reliant on the 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 the Company. The 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. The Company may terminate coverage of the Over-Age Dependent if the Company determines the Dependent child is no longer reliant on the Subscriber for support or is no longer intellectually or physically disabled to the extent he is incapable of sustaining employment.

Partial Hospitalization Programs – Programs that provide structured and medically supervised day, evening or night treatment programs for at least four (4) hours a day and three (3) days a week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical and nursing) as those provided in a Hospital except that the patient is in the program less than 24-hours a day. The patient is not considered a resident at the program. The range of services addresses a Mental Health and substance-related disorder through an individualized treatment plan that a coordinated multidisciplinary treatment team provides.

Participating Pharmacy – See Network Pharmacy.

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

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

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

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

Prescription Drugs – Medications, which include 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 Limitations and Exclusions.

Prescription Drug Coinsurance – The sharing of Allowable Charges for Prescription Drugs. 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 Prescription Drug Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Prescription Drugs to determine the Member's financial responsibility. Our percentage will be applied to the Allowable Charges for Prescription Drugs to determine the Benefits provided. A different Prescription Drug Coinsurance may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

Prescription Drug Copayment – The amount You must pay for each prescription at a Participating Pharmacy when You fill a prescription You may have to pay a different Copayment for the different drug tiers when You buy drugs at a retail pharmacy or through the mail.

Prescription Drug Formulary – A list of specific Prescription Drugs that this Contract covers.

Preventive or Wellness Care – Services designed to effectively prevent or screen for a disease for which an effective treatment exists when it is 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 (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage, or adoption. The attending Physician must order these services. These services must also require the technical skills of an RN or LPN.

We determine which services are Private Duty Nursing Services. Private Duty Nursing Services that are determined by Us to be Custodial Care are not covered.

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. Limb prostheses are artificial limbs that are designed to maximize patients' function, stability, and safety; that are not surgically implanted; and that are used to replace a missing limb. Limb prosthetics do not include artificial eyes, ears, nose, 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 a prosthesis by replacing 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 that 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. Blue Connect Provider – A Provider that has a signed contract with Us to participate in the Blue Connect Provider Network. This Provider is also referred to as a Network Provider or In-Network Provider.

B. Participating Provider – A Provider that does not have a signed contract to participate with the Blue Connect Network, but has a signed contract to participate with HMOLA, Blue Cross and Blue Shield of Louisiana, or another Blue Cross and Blue Shield plan.

C. Non-Participating Provider – A Provider that does not have a signed contract to participate with the Blue Connect Network, HMOLA, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.

Pulmonary Rehabilitation – A comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.

Qualified Health Plan – A plan that qualifies to be sold through the Exchange under Section 1301 of the Patient Protection and Affordable Care Act.

Quality Blue Provider – Any Provider who has signed a contract to participate in the Quality Blue program. Currently, Quality Blue Providers include family practitioners, general practitioners, pediatricians, internists, geriatricians, nurse practitioners and physician assistants, but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, You may review a Provider directory on Our website at www.bcbsla.com or contact Our customer service department at the number on the ID card.

Rehabilitative Care – Healthcare services and devices that help someone keep, resume, or improve skills and functioning for daily living that have been lost or impaired because the person was sick, hurt, or disabled. These services may include Physical Therapy, Occupational Therapy, Speech/Language Pathology Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.

Remote Patient Therapy – A mode of delivering healthcare services that involves the collection of and electronic transmission of biometric data that are analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. Remote Patient Therapy services must be ordered by a licensed Physician, physician assistant, advanced practice registered nurse, or other qualified healthcare Provider who has examined the patient and with whom the patient has an established, documented, and ongoing relationship.

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

Rescission – Cancellation or discontinuance of coverage that has a retroactive effect. This includes a cancellation that treats a policy as void from the time of enrollment or a cancellation that voids Benefits paid up to one (1) year before the cancellation.

Residential Treatment Center – A 24-hour, non-acute care treatment setting to actively treat specific impairments of Mental Health or substance use disorders.

Retail Health Clinic – A non-Emergency medical health clinic that provides limited primary care services and operates generally in retail stores and outlets.

Serious and Complex Condition – As used in the context of continuity of healthcare services, this term means:

A. For an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

B. For a chronic illness or condition, a condition that is:

    1. life-threatening, degenerative, potentially disabling, or congenital; and

    2. requires specialized medical care over a prolonged period of time.

Service Area – Those parishes in Louisiana shown in the Blue Connect Provider Directory, which lists all Blue Connect 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 not a nursing home or a unit within a Hospital (unless We approved skilled nursing in the nursing home or unit within a Hospital). The facility provides:

A. Inpatient medical care, treatment, and skilled nursing care as defined by Medicare and that meets the Medicare requirements for this type of facility or unit;

B. Full-time supervision by at least one (1) Physician or registered nurse;

C. 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 to provide an intensive level of care for critically ill patients, such as an intermediate care neonatal unit, telemetry unit for heart patients, or an isolation unit.

Special Enrollment Period – The 60-day period of time outside of the Open Enrollment Period when a Subscriber and eligible Dependents may enroll for coverage under this Contract or be removed from coverage under this Contact.

Specialist – A Physician who is not practicing as a Primary Care Physician (PCP).

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

A. specialized patient training on the administering 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 storing; or

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 same active ingredient. Biosimilars are not considered Generic Drugs.

Speech/Language Pathology Therapy – The treatment used to manage speech/language, speech/language development, cognitive communication, and swallowing disorders. The therapy must be used to improve or restore function.

Spouse – The Subscriber's legal Spouse.

Subscriber – Someone who is a resident of this state, who has satisfied the specifications in the Schedule of Eligibility, who has signed the Application for Individual Coverage or had an appropriate legal representative sign the application for him, who has enrolled for coverage, and to whom We have issued this 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, including vaginal deliveries and caesarean sections.

D. Usual and related pre-operative and post-operative care.

E. Other procedures as defined and approved by Us.

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 the Provider and patient are in separate locations.

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

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

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

Urgent Care Center – A clinic with extended office hours which provides Urgent Care to patients on an unscheduled basis without need for an 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 using healthcare services, procedures, and facilities.

Well Baby Care – Routine examinations of an infant who is younger than twenty-four (24) months old for whom no diagnosis is made.

ARTICLE III. SCHEDULE OF ELIGIBILITY

By amendment, We may delete or revise any eligibility requirement in this Contract that is not mandated by state or federal law.

A. Open Enrollment Period

A Subscriber and Dependents will be able to enroll on this Contract during the Open Enrollment Period. No enrollment changes will be allowed after an Open Enrollment Period closes unless a Special Enrollment event exists as explained below or the Member disenrolls from coverage.

B. Eligibility

1. Subscriber –

   a. On-Exchange: A Subscriber is someone who has applied, either personally or through a legal representative, for individual health insurance coverage to the Exchange, and has been determined by the Exchange as eligible for this Contract. When You apply and while You are covered, You must be a citizen, national, or have legal presence in the United States and be a resident of the state of Louisiana. You cannot be incarcerated, unless incarceration is pending the disposition of charges.

   b. Off-Exchange: A Subscriber is someone who has signed the Application for Individual Health Coverage, or someone on whose behalf an application has been signed by the appropriate legal representative, and which We have accepted. You must be a Louisiana resident when You apply and while covered.

2. Dependent – To be eligible to apply as a Dependent, You must meet the following criteria when applying. To be eligible to keep coverage, You must continue to meet the criteria. If You do not continually meet the criteria, We may determine that You are 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; or

      (5) a child supported by the Subscriber according 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 Contract before turning age 26, and is able to remain covered on the Contract once turning age 26 because he meets the definition and requirements of an Over-Age Dependent.

C. Classes of Coverage

The following classes of coverage are available under this Contract:

1. Subscriber Only –coverage for the Subscriber only.

2. Child Only – coverage for one (1) child who is less than twenty-one (21) years old as of the first day of the year and with no Spouse or other Dependents enrolled on the Contract. If a Spouse or Dependent is added to the Contract, or the Subscriber is 21 years or older as of the first day of the year, the Contract will no longer be considered a Child Only Contract and different rules or laws may apply. Unless required by law, We will accept only one (1) child per Child Only Contract. If multiple children are required to be covered on a single Child Only Contract, appropriate premium will be charged.

3. Subscriber and Spouse – coverage for the Subscriber and Spouse.

4. Subscriber and family – coverage for the Subscriber, Spouse, and one (1) or more Dependent children.

5. Subscriber and children – coverage for the Subscriber and one (1) or more Dependent children.

D. Effective Date of Coverage

1. An individual may apply for coverage under this Contract through Us or the Exchange and may include any eligible Dependents in such application.

2. No one for whom coverage is sought will be covered under this Contract unless We or the Exchange approved the Application for Individual Health Coverage and that approval has been evidenced by issuing an identification (ID) card or other written notice of approval. Payment of premiums to Us for anyone for whom coverage is sought will not effectuate coverage unless and until Our ID card or other written approval has been issued, and in the absence of such issuance, Our liability will be limited to refund of the amount of premiums paid.

3. When an application has been approved and any premiums for coverage have been paid in advance as required by this Contract, coverage will begin on the date We or the Exchange assigns as Your Effective Date. No Claims will be paid for dates of service before Your Effective Date.

E. Special Enrollment

Certain specified events provide You with the opportunity to enroll or disenroll Yourself or eligible Dependents from coverage on this Contract outside of the Open Enrollment Period. These are special enrollment events. Enrollment or disenrollment must be made during the Special Enrollment Period specified in this Contract. Members who lose this or other coverage because they do not pay their premium or lose this or other coverage for cause (such as filing fraudulent Claims or an intentional misrepresentation of a material fact in connection with the Contract) are not Special Enrollees and have no special enrollment rights.

1. The following are examples of special enrollment events for all Contracts purchased both On-Exchange and Off-Exchange:

    a. Loss of minimum essential coverage during the year as a consequence of:

        (1) loss of eligibility for coverage under another plan the individual was enrolled in as a result of termination of employment (except for gross misconduct), reduction of work hours, death, divorce, or loss of Dependent status under that health plan;

        (2) changing residence to an area not served by the health plan under which the individual was enrolled;

        (3) another health plan stops offering benefits to a certain class of similarly situated individuals of which the individual was a member;

        (4) termination of employer contributions towards a person's coverage under another health plan in which the individual was enrolled; and

        (5) exhaustion of COBRA continuation coverage.

An individual requesting special enrollment under this section because of loss of other minimum essential coverage must request enrollment under this Contract within 60 days after the other coverage ends (or after the employer stops contributing toward the other coverage). Such enrollment must be received by a HMO Louisiana, Inc. office within 60 days after loss of other coverage. The request will be denied and coverage will not be available if HMO Louisiana, Inc. does not receive the request for enrollment form within 60 days after the loss of other coverage.

Minimum essential coverage for Special Enrollment purposes under this section means those included under that term by Internal Revenue Code Section 5000A, as for example:

- Medicare;
- Medicaid;
- Children's Health Insurance Program (CHIP);
- health coverage provided by the United States Armed Forces under Chapter 55 of Title 10 of the United States Code, including Tricare;
- health coverage program provided by the United States Secretary of Veterans Affairs in coordination with the United States Secretary of Health and Human Services under Chapters 17 and 18 of Title 38 of the United States Code;
- the health plan for Peace Corps volunteers under Section 2504(e) of Title 22 of the United States Code;
- the Nonappropriated Fund Health Benefits Program of the United States Department of Defense established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995;
- health plans bought in the individual health insurance market within a state of the United States;
- coverage under the health benefits risk pool of a State of the United States;
- an eligible employer-sponsored health plan which is offered in the small or large group markets within a State of the United States, or a governmental health plan, which is not an excepted Benefit; and
- any other plan recognized as minimum essential coverage by the United States Secretary of Health and Human Services in coordination with the United States Secretary of the Treasury for purposes of Internal Revenue Code Section 5000A.

b. A Qualified Health Plan violates a material provision of its Contract.

c. New determination of eligibility or ineligibility for the advanced payments of the premium tax credit or change in eligibility for cost-sharing reductions in the Exchange.

d. The Subscriber gaining a Dependent or becoming a Dependent through marriage, birth, adoption, placement for adoption or mandate granting legal or provisional custody of the child or grandchild. The Special Enrollment Period described in this subparagraph is a period of 60 days and will begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, legal placement for adoption, or mandate granting legal or provisional custody of a child or grandchild. Premiums may be adjusted for the additional coverage. We must receive Your request to enroll Yourself or someone else because of these events within 60 days from the date of the event. If the request for enrollment is not made timely, the request will be denied.

2. Examples of additional special enrollment events for Contracts purchased only on-Exchange are:

   a. gaining access to new Qualified Health Plans because of a permanent move;

b. being an Indian, as defined in Section 4 of the Indian Health Care Improvement Act;

c. meeting other exceptional circumstances as determined by the Exchange;

d. gaining new status as a United States citizen, national, or other legal presence in the United States; and

e. enrollment or non-enrollment in a Qualified Health Plan was due to an error, misrepresentation or inaction of an officer, employee or agent of the Exchange or the United States Department of Health and Human Services, or their instrumentalities.

f. Your request to enroll Yourself or other eligible Dependents must be received by HMO Louisiana, Inc. within 60 days from the date of the event. If the request for enrollment is not timely made, the request will be denied.

3. Automatic Coverage for Newly Born Infants During Special Enrollment Periods

There is a 1- month period of automatic coverage for natural born or adopted Newly Born Infants. Any period of automatic coverage for Newly Born Infants runs concurrently with the Special Enrollment Period for requesting Us or the Exchange to add these infants to this Contract.

a. Newly Born Infants (Newborns) – If a child is born to a Member covered under this Contract, the following will apply:

(1) Such child will be covered automatically for 1 month from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to home, whichever is longer. This is the automatic coverage period. This period of automatic coverage for the child will be provided if You notify the Exchange or HMO Louisiana, Inc. of the birth of the child. Coverage for the child will continue until the expiration of the period of automatic coverage, unless otherwise determined by Us or the Exchange, or the Newly Born Infant is added as a Dependent to this Contract. Coverage is made by applying to Us or Exchange, paying premiums required for coverage, and completing any required forms.

(2) If the enrollment request is not received with this 1-month period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the Newly Born Infant must be made at Open Enrollment Period or under another special enrollment provision.

b. Newly Born Adopted Infants – If within 1 month of the birth of a child, the child is either: legally placed into Subscriber's home for adoption after 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, the following will apply:

(1) The Newly Born Adopted Infant will be covered automatically for 1 month. The 1-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 the child 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 until the expiration of the period of automatic coverage, unless otherwise determined by Us or the Exchange, or the Newly Born Adopted Infant is added as a Dependent to this Contract. Coverage is made by applying to Us or Exchange, paying premiums required for coverage, and completing any required forms.

(2) If the enrollment request is not received within this 1-month period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the Newly Born Adopted Infant must be made at Open Enrollment Period or under another special enrollment provision.

By amendment, We may delete or revise any Benefit in this Contract that is not mandated by state or federal law.

ARTICLE IV. BENEFITS

A. Benefit Categories

1. Network Benefits (In-Network) – Benefits for medical care received from a Blue Connect Network Provider. When a Member receives care from a Network Provider, he will receive the highest level of Benefits under this Contract.

2. Non-Network Benefits (Out-of-Network) – Benefits for medical care received from a Provider who is not contracted with Us as a Blue Connect Network Provider. Participating Providers and Non-Participating Providers are not contracted with Our Blue Connect Provider Network. When a Member receives care from a Non-Network Provider, the Member will receive a lower level of Benefits under this Contract.

B. Deductible Amounts

1. Subject to the Deductible Amounts shown on the Schedule of Benefits, the maximum limitations hereinafter provided, and other terms and provisions of this Contract, We will provide Benefits according to the Coinsurance shown on the Schedule of Benefits toward Allowable Charges incurred for Covered Services by a Member during a Benefit Period. The following Deductible Amounts may apply to Benefits provided by this Contract.

   a. Individual Deductible Amount: The dollar amount, as shown on the Schedule of Benefits, of charges for Covered Services that You must pay within a Benefit Period before this Contract starts paying Benefits. A separate Deductible Amount may apply to certain Covered Services if shown on the Schedule of Benefits.

   b. Family Deductible Amount: For Members in a class of coverage with more than 1 Member, this aggregate amount shown on the Schedule of Benefits is the maximum Deductible Amount that the family must pay before this Contract starts paying Benefits. Once the family has met its Family Deductible Amount, this Contract starts paying Benefits for all members of the family, even if each family member has not met his Individual Deductible Amount. No family member may contribute more than the Individual Deductible Amount to satisfy the aggregate amount required of a family. Only Individual Deductible Amounts accrue to the Family Deductible Amount.

   c. Prescription Drug Deductible Amount: The dollar amount, if shown on the Schedule of Benefits, which each Member must pay within a Benefit Period before paying a Prescription Drug Copayment. A Prescription Drug Deductible Amount is in addition to other Deductible Amounts. It does not accrue to the Individual Deductible Amount or the Family Deductible Amount.

2. Each of the Deductible Amounts listed on the Schedule of Benefits may have separate Network and Non-Network amounts. Amounts that apply to a Network Deductible Amount do not apply to a Non-Network Deductible Amount. Amounts that apply to a Non-Network Deductible Amount do not apply to a Network Deductible Amount.

3. We will apply the Member's Claims to the appropriate Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from the Member, then when the Member receives Covered Services from another Provider, that Provider also collects the Member's Deductible Amount. This generally occurs when the Member's Claims have not been received and processed by Us. Our system will only show the Deductible Amount applied for Claims that have been processed.

   Therefore, the Member may need to pay toward the Deductible Amount until his Claims are submitted and processed, showing that the Deductible Amount has been met. If the Member overpays his Deductible Amount, the Member is entitled to receive a refund from the Provider to whom the overpayment was made.

4. If We pay a healthcare Provider amounts that are Your responsibility, such as Copayments or the Deductible Amount and Coinsurance, We may collect such amounts directly from You. You agree that We have the right to collect such amounts from You.

C. Coinsurance Amount

If a Coinsurance is shown on the Schedule of Benefits for a Covered Service, the Member must first pay any Deductible Amount before a Coinsurance is applied. After any Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Contract, We will provide Benefits in the Coinsurance shown on the Schedule of Benefits toward Allowable Charges for Covered Services. Our actual payment to a Provider or payment to the Member satisfies Our obligation to provide Benefits under this Contract.

D. Copayment Services

The Member may pay one or more Copayments 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 shown on the Schedule of Benefits.

If applicable, the office visit Copayment may be reduced when services are rendered by a Quality Blue Provider. Quality Blue Providers include any Provider who has signed a contract to participate in the Quality Blue program.

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 therapy;

    f. Low-Tech Imaging;

    g. Lab tests;

    h. Dialysis;

    i. Infusion therapy; and

    j. Medical and surgical supplies.

E. Out-of-Pocket Amount

1. After the Member has met the Out-of-Pocket Amount shown on the *Schedule of Benefits*, We will pay 100% of the Allowable Charges for Covered Services for the remainder of the Benefit Period.

2. The following accrue to the Out-of-Pocket Amount of this Contract:

    a. Deductible Amount;

    b. Coinsurance; and

c. Copayments.

3. The following do not accrue to the Out-of-Pocket Amount of this Contract:

   a. any charges that are more than the Allowable Charge;

   b. any penalties the Member or Provider must pay; and

   c. charges for non-Covered Services.

4. Amounts paid by Members for Covered Services provided by Participating and Non-Participating (collectively Non-Network) Providers will accrue to the Out-of-Pocket Amount for Network Providers when required by law.

5. Services for Essential Health Benefits of a Non-Network Providers will accrue to the Out-of-Pocket Amount for Network Providers.

F. Accumulator Transfers

Members' needs sometimes require that they transfer from one Contract to another. Types of transfers include, but are not limited to, moving from one Employer's plan to another, from a change in assignment to a different plan variation of the same Qualified Health Plan during a Benefit Period, from a Group plan to an individual Contract, an individual Contract to a Group plan, or a Blue Cross and Blue Shield of Louisiana plan to an HMO Louisiana, Inc. Contract.

The type of transfer being made determines whether the Member’s accumulators are carried from the old Contract to the new Contract. Accumulators include, but are not limited to, Deductible Amounts, Out-of-Pocket Amounts, and Benefit Period Maximums.

G. Medicare Coverage

If a Member becomes eligible for Medicare, the Member should apply for and enroll in Medicare Part A and Part B and use Providers who accept Medicare in order to receive full coverage of benefits under Medicare and full coverage of Benefits under this Contract. We will assume a Member that is eligible for Medicare has enrolled in Medicare and uses Providers who accept Medicare once eligible for benefits thereunder.

If a Member covered under this Contract is eligible for Medicare Part B, We may take into account the benefits that the Member is eligible for under Medicare Part B, regardless of whether the Member has actually enrolled for such coverage. In other words, even if a Member has not enrolled in Medicare Part B, We may reduce coverage of the Member’s Claims for any and/or all Covered Services by the benefits that the Member is eligible for under Medicare Part B, and then pay the remaining Claims amounts.

The reduction of coverage will occur as described herein. We will reduce Our Allowable Charge by 80%. The Member will be responsible for payment of the 80% reduction. The remaining 20% of Our Allowable Charge will be paid by Us at 100% after the Member has paid any applicable Deductible Amounts and the remaining 20% will not be subject to any additional Copayments or Coinsurance. None of the 80% of Our Allowable Charge the Member may be responsible for paying is deemed to be payment for a Covered Service and those amounts will not apply toward the Out-of-Pocket Amount or any Deductible Amounts.

As a result, if this reduction is applied, the Member will be responsible for 80% of Our Allowable Charge, plus any Deductible Amounts on the remaining 20%, which will result in the Member paying significantly higher costs for the services than if the Member had enrolled in Medicare**.**

ARTICLE V. HOSPITAL BENEFITS

All Admissions (including elective or non-Emergency, Emergency, Pregnancy Care, Mental Disorders and substance use disorders Admissions) must be Authorized as outlined on the Schedule of Benefits and in the *Care Management Article*.

In addition, at regular intervals during the Inpatient stay, We will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care.

You must pay all Copayments, any Deductible Amount and Coinsurance shown on 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 or clinic as well as the facility.

If a Member goes to a Hospital Emergency room for an Emergency Medical Condition, and the Member is admitted to the Hospital, the Emergency Admission must be Authorized. This is not a prior Authorization requirement.

If the Member is not receiving Emergency Medical Services and is admitted to a Non-Network Hospital, Benefits will be processed at the Non-Network Deductible Amount and Coinsurance level shown on the *Schedule of Benefits*.

If the Member is receiving Emergency Medical Services and is admitted to a Non-Network Hospital, Benefits will be processed at the higher Blue Connect Network Deductible Amount and Coinsurance level shown on the *Schedule of Benefits*.

As permitted by applicable law, once stabilized, the Member must move to a Blue Connect Network Hospital or may be subject to a penalty shown on the Schedule of Benefits.

The Member may also be balanced billed by the Non-Participating Hospital, except to the extent balance billing is prohibited by applicable law.

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

A. Inpatient Bed, Board and General Nursing Services

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.
4. In a Residential Treatment Center for Members using Mental Health and substance use disorder Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

1. Use of operating, delivery, recovery and treatment rooms and equipment.
2. Drugs and medicines including take-home Prescription Drugs.
3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, 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 a Hospital employee.

C. Emergency Room Benefits (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 72 hours of a scheduled procedure performed at an Inpatient or Outpatient Facility.

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and surgical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. You must pay any Copayments, Deductible Amount, and Coinsurance shown on 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.

   b. 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.

   c. When performed in the Physician 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 Medical or Surgical Services – When Medically Necessary multiple services (concurrent, successive, or other multiple medical or surgical services) are performed at the same encounter, Benefits will be paid as follows:

   a. Primary Service

      (1) The primary, or major service, will be determined by Us.

      (2) Benefits for the primary service will be based on the Allowable Charge.

   b. Secondary Services

      A secondary service is a service performed in addition to the primary service as determined by Us. The Allowable Charge for any secondary service will be based on a percentage of the Allowable Charge that would be applied had the secondary service been the primary service.

   c. Incidental Service

      (1) An incidental service is one carried out at the same time as a primary service as determined by Us.

      (2) Covered incidental services are not reimbursed separately. The Allowable Charge for the primary service includes coverage for any incidental service. If the primary service is not covered, any incidental service will not be covered.

   d. Unbundled Services

      (1) Unbundling occurs when two (2) or more service codes are used to describe a medical or surgical service performed when a single, more comprehensive service code exists that accurately describes the entire medical or surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by Us.

      (2) The Allowable Charge of comprehensive service code includes the charge for the unbundled services. We will provide Benefits according to the proper comprehensive service code, as determined by Us.

   e. Mutually Exclusive Services

      (1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session on the same patient, on the same date of service, and for which separate billings are made. Mutually exclusive services may also include different service codes and descriptions for

the same type of services in which the Physician should be submitting only one (1) of the codes. One (1) or more of the duplicative services is not reimbursable as it should be reimbursed only one time.

(2) The Allowable Charge includes all services performed at the same encounter. Any and all services, 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 Copayments, Deductible Amount, and Coinsurance, but are not mandatory 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; and

3. Consultation (as defined in this Contract).

C. Outpatient Medical and Surgical Services

1. Home, office, and other Outpatient visits for examining, diagnosing, and treating an illness or injury. Benefits for Outpatient medical services do not include separate payments for routine pre-operative and post-operative medical visits for Surgery or Pregnancy Care;

2. Consultation (as defined in this Contract);

3. Diagnostic Services;

4. services of an Ambulatory Surgical Center; and

5. services of an Urgent Care Center.

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

Prescription Drugs are covered as shown in either Option 1 or Option 2 below. See Your Schedule of Benefits for which Prescription Drug Benefit option applies to You.

A. The Prescription Drugs Must Be Dispensed Properly

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 on the Schedule of Benefits.

B. Some Pharmacies Have Contracted with Us

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 based on the amount We pay Our Pharmacy Benefit Manager. We use the amount We pay Our Pharmacy Benefit Manager to base Our payment for Your Covered Prescription Drugs and the amount that You must pay for covered Prescription Drugs.

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

C. Present a Valid ID Card When You Buy Prescription Drugs

When buying covered Prescription Drugs at a Network Pharmacy, present a valid ID card. The Prescription Drug Deductible Amount, 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 Amount, the Network Pharmacy may collect 100% of the discounted costs of the drug at the point of sale. If the Member has met his Prescription Drug Deductible Amount, he will pay the Copayment amount or Coinsurance shown on the Schedule of Benefits. The Network 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. For covered drugs that are included 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 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 number on the ID card.

You may also call Us at the number on the 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 formulary exception process. This process allows You, Your designee or Your prescribing healthcare Provider to ask for a formulary exception 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 request is not approved, You may file an internal or external formulary exception request to Us.

Option 1 – Prescription Drug Benefits (3 Tier)

1. The Prescription Drug Deductible Amount, 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 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 the highest drug tier (Member cost share amount).

    a. Tier 1 – Primarily Generic Drugs (traditional and specialty), although some Brand-Name Drugs may fall into this category

    b. Tier 2 – Includes traditional brands and generics, specialty brands and generics, and biosimilars

    c. Tier 3 – Includes traditional brands and generics, specialty brands and generics, biosimilars, and covered compound drugs

Option 2 – Prescription Drug Benefits (2 Tier)

1. After the applicable Deductible Amount has been met, Benefits for Prescription Drugs dispensed at retail or through the mail will be provided at the Coinsurance shown on the *Schedule of Benefits*. Generic Drugs and Brand-Name Drugs may be subject to different Coinsurances.

2. If a formulary exception request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary at the applicable Generic Drug or Brand-Name Drug cost share.

    a. Tier 1 – Generic Drugs

    b. Tier 2 – Brand-Name 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 or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies 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 at **www.bcbsla.com/pharmacy** or by calling customer service at the number on the ID card. If the Prescription Drug requires prior Authorization, the Member's Physician must call Medical Authorization at the number on the 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 (for example, refill before 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. 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 clinical studies; or

   d. as determined by Us.

4. Step Therapy – Certain drugs and drug classes are subject to Step Therapy. In some cases, We may require the Member to first try 1 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 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.

5. Step Therapy Overrides – Your Provider prescribing the Prescription Drug may request a Step Therapy override.

   a. Step Therapy overrides are provided for stage-four advanced, metastatic cancer or associated conditions when certain criteria exist; step therapy overrides are also provided for other conditions when certain criteria are met.

   b. When a Step Therapy Override request is submitted, We will respond to the request within seventy-two hours unless exigent circumstances exist, in which case We will respond to the request within twenty-four hours. If We do not make the determination timely, then the override request is considered approved.

   c. If a Step Therapy Override request is denied, an Appeal can be submitted.

F. This Contract Covers Select Diabetic Supplies, Including, but Not Limited to, Necessary Continuous Glucose Monitors and Associated Supplies, Insulin Syringes, and Test Strips Under the Prescription Drug Benefit

G. When You Buy Covered Prescription Drugs from a Pharmacy that Has Not Contracted with Us

When You buy covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when You file a paper Claim with Us or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that We pay Our Pharmacy Benefit Manager for covered Prescription Drugs.

H. When You Buy Prescription Drugs Outside of the United States

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, call Us or Our Pharmacy Benefit Manager at the number on the ID card.

I. We May Disclose Information About Your Prescription Drug Usage

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.

J. We Use Any Savings or Rebates to Stabilize Rates

Any savings or rebates We receive on the cost of drugs purchased under this Contract from drug manufacturers are used to stabilize rates. You may be subject to an excess consumer cost burden when Covered Prescription Drugs are purchased under this Contract. (La. R.S. 22:976.)

ARTICLE VIII. PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to a Member. If a Member receives Covered Services for Preventive or Wellness Care from a Network Provider, Benefits will be paid at 100% of the Allowable Charge, unless otherwise stated below. If a Member receives Covered Services for Preventive or Wellness Care from a Non-Network Provider, Benefits will be subject to Copayment amounts (if applicable) and Coinsurance shown on the Schedule of Benefits. The Deductible Amount will apply to Covered Services received from a Non-Network Provider, unless otherwise stated below. Preventive or Wellness Care services may be subject to other limitations shown on the Schedule of Benefits.

A. Well Woman Examinations

1. Routine annual visits to an obstetrician or gynecologist. Additional visits that Your obstetrician or gynecologist recommends may be subject to a Deductible Amount, Copayment or Coinsurance shown on the Schedule of Benefits, unless they are preventive services.

2. One routine Pap smear per Benefit Period.

3. All film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost to You when obtained from a Network Provider. Mammograms obtained from a Non-Network Provider will be subject to Coinsurance as shown on the Schedule of Benefits.

4. When required by applicable law, Breast MRIs will be covered under this Preventive or Wellness Care Benefit, but not at one hundred percent (100%). The Deductible Amount will not apply for Breast MRIs. Benefits will be subject to Coinsurance shown on the Schedule of Benefits for High-Tech Imaging Services. Any MRIs that are not covered under this Preventive or Wellness Care Benefit may be covered under standard contract Benefits for High-Tech Imaging Services when Medically Necessary.

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 or Wellness Care Benefit include 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 or Wellness Care Benefit. Your Contract covers these High-Tech Imaging Services under standard Contract Benefits when the tests are Medically Necessary.

2. Well Baby Care – Routine examinations will be covered for infants younger than twenty-four (24) months old for whom no diagnosis is made. Routine examinations ordered after the infant reaches twenty-four (24) months will be subject to the Routine Wellness Physical Exam Benefit.

3. Prostate Cancer Screening – 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. The Individual Deductible Amount does not apply.

   A second visit will be permitted if recommended by Your Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

4. Colorectal Cancer Screening – Fecal Immunochemical Test (FIT) for blood, Cologuard (FIT-fecal) DNA testing, Computed Tomographic (CT) colonography, flexible sigmoidoscopy, or routine colonoscopy provided according to 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.

   Selected generic Physician prescribed colonoscopy preparation and supplies for routine colonoscopies covered under the Preventive or Wellness Care Benefit will be covered at first dollar when You go to a Network Pharmacy. Routine colorectal cancer screenings are not services otherwise excluded from Benefits because We deem the services to be Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to You only under the following circumstances: Physicians prescribe brand-name colonoscopy preparation and supplies because of Your inability to tolerate selected generic colonoscopy preparation and supplies.

5. Bone Mass Measurement – scientifically proven tests for diagnosing and treating osteoporosis if a Member is:

   a. an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;

   b. an individual receiving long-term steroid therapy; or

   c. an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

6. BRCA1 & BRCA2 Genetic Testing – Genetic testing of BRCA1 and BRCA2 genes will be covered at no cost to You 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.

C. Preventive or Wellness Care Required by the Patient Protection and Affordable Care Act

Services recommended by the United States Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration are covered. You may view a copy of Our Preventive Care Services brochure by visiting Our website at: **www.bcbsla.com/preventive**.

The list of covered services changes from time to time. To check the current list of recommended Preventive or Wellness Care services required by PPACA, go to the United States Department of Health and Human Services' website at: **https://healthcare.gov/preventive-care-benefits/** or call customer service at the number on the ID card.

Members may obtain information on the exceptions process related to the coverage of contraceptive services on Our website **[bcbsla.com/birthcontrol]**. This exception process is only applicable to plans which cover contraceptive services.

D. New Recommended Preventive or Wellness Care Services

New services are covered by this Contract on the date required by law for such coverage.

E. COVID-19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by Your Physician for the purpose of making clinical decisions or treating You if You are suspected of having COVID-19 are covered under this

Contract. When You go to a Network or Non-Network Provider, these services are covered, up to the Network allowable, at no cost when required by applicable law. Non-Network Providers are able to balance bill You up to their full-billed charge. Balance bills do not apply to the Out-of-Pocket Amount. When not required by applicable law to be covered at no cost to You, Your Contract may pay according to the Contract Benefits, including Your payment of applicable Copayments, Deductible Amounts, and Coinsurances, as shown on the Schedule of Benefits for Network or Non-Network Providers.

The approved diagnostic tests and antibody tests do not include a test used for employment-related or public health surveillance testing and, regardless of medical necessity, any COVID-19 diagnostic tests or antibody tests for those purposes are excluded from coverage.

Only when required by applicable law, eight (8) approved OTC COVID-19 tests are covered for each Member every thirty (30) days. Approved OTC COVID-19 tests can be obtained from the Pharmacy Benefit Manager's direct-to-consumer shipping program method or from a pharmacy. This coverage is subject to any reimbursement limitations permitted by law.

If applicable federal or state law changes during the Benefit Period, any and all coverage for COVID-19 procedures, services, tests, or treatments will also change in accordance with those applicable laws.

ARTICLE IX. MENTAL HEALTH BENEFITS

Treatment of Mental Health is covered. Treatment must be given by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treating Mental Health do not include counseling services such as career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling.

Your Contract covers the first follow-up visit after discharge from an Inpatient facility for the treatment of Mental Health at no cost to You when performed within seven (7) days of discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to Contract benefits.

ARTICLE X. SUBSTANCE USE DISORDER BENEFITS

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

Your Contract covers the first follow-up visit after discharge from an Inpatient facility for the treatment of substance use disorder at no cost to You when performed within seven (7) days of discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to Contract benefits.

ARTICLE XI. ORAL SURGERY BENEFITS

For Oral Surgery Benefits, Providers in Your medical plan Network, the Blue Cross and Blue Shield of Louisiana Dental Network, or the United Concordia Dental Advantage Plus Network are considered Network Providers. Access these Networks online at **www.bcbsla.com,** or call the customer service telephone number on the ID card for copies of the directories.

A. This Contract Only Covers the Following Services or Procedures

1. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.

2. Extraction of impacted teeth.

3. 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.

4. Excision of exostoses or tori of the jaws and hard palate.

5. Incision and drainage of abscess and treatment of cellulitis.

6. Incision of accessory sinuses, salivary glands, and salivary ducts.

7. Anesthesia for the above services or procedures when rendered by an oral surgeon.

8. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.

9. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when Your 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.

10. Benefits are available for dental services not otherwise covered by this Contract, when specifically required to restore bodily function for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To obtain more information on how to access these medical Benefits, call customer service at the number on the ID card and ask to speak to a Case Manager.

B. Coordination of this Section with Non-Group Stand-Alone Dental Contracts

If a Member has non-group stand-alone dental coverage in addition to this medical Contract, the dental benefits under the non-group stand-alone coverage will be determined first. The benefits under this medical Contract will be determined on a secondary basis and will be reduced, so that no more than the full amount of the Allowable Charge is paid under all policies covering the same Claim or service.

ARTICLE XII. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

Authorization is required for the evaluation of Your suitability for all Solid Organ and Bone Marrow Transplant procedures. For 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 before services being rendered. You or Your Provider must advise Us of the proposed transplant procedure before 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 Providers.

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 Center for Transplants (BDCT) for the specific organ or transplant or by the HMO Louisiana, Inc. (HMOLA) approved 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 at the number on the ID card.

The Organ, Tissue and Bone Marrow Transplant Benefits are shown on the Schedule of Benefits and are not covered under the Non-Network Benefit category. Benefits are provided for Network services only.

2. Benefits for Organ, Tissue and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedures.

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

   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, have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.

   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 Authorization requirements in Care Management.

      The following tissue transplants are covered:

      (1) Blood transfusions;

      (2) Autologous parathyroid transplants;

      (3) Corneal transplants;

      (4) Bone and cartilage grafting;

      (5) Skin grafting;

      (6) Autologous islet cell transplants; and

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

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, have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These bone marrow transplant procedures will be considered on a case-by-case basis.

ARTICLE XIII. PREGNANCY CARE AND NEWBORN CARE BENEFITS

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 **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.

We have several maternity programs available to help pregnant Members deliver healthy babies. Please call Our customer service department at the number on the ID card when You learn You are having a baby. When You call, We will let You know what programs are available to You.

The Member must pay all applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

A. Pregnancy Care Benefits

1. Medical and Surgical Services

   a. Initial office visit and visits during the term of the pregnancy.

   b. Diagnostic Services.

   c. Delivery, including necessary pre-natal and post-natal care.

   d. Medically Necessary abortions required in order to save the life of the mother.

2. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above are covered. 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. As determined by Us, well newborn charges may be covered if the Member under this Contract is the father.

3. Elective deliveries before the 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.

B. Newborn Care for a Dependent Who is Covered at Birth

1. Medical and Surgical services rendered by a Physician, for treatment of illness, prematurity, post maturity, congenital condition and for circumcision of a newborn are covered. Services of a Physician for Inpatient Well Baby Care immediately after delivery until discharge are covered.

2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, post maturity, and congenital condition of a newborn. Charges for services for a well newborn, including the Hospital (nursery) charge, should not be billed separately from the mother's

Hospital bill. As determined by Us, well newborn charges may be covered if the Member under this Contract is the father.

ARTICLE XIV. REHABILITATIVE AND HABILITATIVE CARE BENEFITS

Rehabilitative and Habilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation and Chiropractic Services. Benefits are available when therapy services are rendered by a Provider licensed and practicing within the scope of his license. For care to be considered at an Inpatient Rehabilitation facility, the Member must be able to tolerate a minimum of 3 hours of active therapy per day.

An Inpatient Rehabilitation Admission must be Authorized before the Admission and must begin 72 hours after the discharge from an Inpatient Hospital Admission for the same or similar condition, unless otherwise approved by Us.

Day Rehabilitation Programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation Programs must be Authorized before beginning the program and must begin within 72 hours after discharge from an Inpatient Admission for the same or similar condition, unless otherwise approved by Us.

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including 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 before the receipt of services.

3. Prevention, wellness, and education-related services for Occupational Therapy do 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 before 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 according to the Member’s plan of care;

    b. as part of a Home Health Care agency according to the Member’s plan of care;

    c. to a patient in a nursing home according 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; or

    e. to someone for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider giving the diagnosis. The diagnosis must have been made within the previous 90 days. The physical therapist must provide the healthcare Provider who gave

the diagnosis with a plan of care for Physical Therapy services within the first 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 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 before 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 XV. PEDIATRIC DENTAL CARE BENEFITS

The dental Benefits described in this section are available for Members under the age of nineteen (19) only.

Members who attain age nineteen (19) during a Plan Year will continue to have these Benefits until the end of that Plan Year. Members that age off the coverage under this section may be eligible to purchase other dental coverage through Blue Cross and Blue Shield of Louisiana. Please contact a customer service representative for details. The Schedule of Benefits controls the Benefits covered, the frequency with which they are covered, and the cost sharing applicable to each Benefit. The Benefits offered are limited.

In accordance with federal law, We will provide Benefits for all required pediatric dental services. Services will be subject to any duration and frequency limits and exclusions as identified in the federal benchmark plan.

A. Definitions *(Applicable only to this Pediatric Dental Care Benefits Article of this plan)*

1. Allowable Charge – The lesser of the billed charge or the amount established by UCD as the greatest amount this plan will allow for a specific service covered under the terms of this plan.

2. Amalgam – A durable metal alloy comprised of silver, copper, tin and mercury, used in dental restorations.

3. Authorization (Authorized) – A determination by UCD regarding a dental 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.

4. Benefits – Coverage for dental services, treatments or procedures provided under this plan. Benefits are based on the Allowable Charge for Covered Services and the Schedule of Benefits.

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

6. Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a percentage. Once the Member has met any applicable Deductible, the Company's percentage will be applied to the Allowable Charge for Covered Services to determine the Benefits provided.

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

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

9. Crown – A tooth-shaped cap that is placed over a tooth to cover it and restore its shape and size, strength, and improve its appearance. When a Crown is cemented into place, it fully encases the entire visible portion of a tooth that lies at and above the gum line.

10. Deductible – The dollar amount, if shown on the Schedule of Benefits, of Allowable Charges for Covered Services that each Member must pay within a Benefit Period before payments are made under this plan. If shown on the Schedule of Benefits, the Deductible may be waived for certain services.

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

    a. represents himself/herself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;

    b. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a Filling, Crown, denture, or other appliance; or

    c. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair Prosthetic Dentures, bridges, or other substitute for natural teeth to the user or prospective user.

12. Dental Implants – An artificial device that replaces the tooth root and may anchor an artificial tooth, bridge or denture.

13. Dental Necessity or Dentally Necessary – A dental service or procedure that is determined by UCD to either establish or maintain a patient's dental health based on professional diagnostic judgment and the prevailing standards of care in the professional community. The determination will be made by a Dentist in accordance with guidelines established by UCD.

14. Dentist – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioners under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

15. Endodontic (Pulpal) Therapy – A dental procedure that is performed when the decay in a child's tooth reaches into the pulp (nerve) tissue. The infected part of the nerve tissue within the crown portion of the tooth is removed to prevent further inflammation and spread of disease (caries). During this treatment, the diseased pulp tissue is partially or completely removed from both the crown and the roots of the tooth. The canals are cleansed, disinfected, and filled with a special material.

16. Filling – A dental restorative material used to restore the function, integrity and form of missing tooth structure, which may result from caries or external trauma.

17. Fluoride Treatment – Fluoride is a chemical substance that helps prevent tooth decay by making the tooth more resistant to acid attacks from plaque bacteria and sugars in the mouth. It also reverses early decay.

Fluoride treatment refers to the direct application of a substance containing this substance to the tooth enamel.

18. Gingivectomy – Surgical removal of gum tissue.

19. Gingivoplasty – A surgical procedure to reshape or repair the gums.

20. Inlay – A custom-made solid substance that is fitted into a cavity in a tooth between the cusps, which is cemented into place to restore its biting surface.

21. Occlusal Guard – A horseshoe shaped piece of plastic which is worn over the teeth to protect them against damage caused by clenching or grinding. It works by creating a physical barrier between the patient's upper and lower teeth so that he/she bites against the plastic rather than wearing down his teeth.

22. Onlay – A custom-made solid substance that works like an Inlay but covers one or more cusps or the entire biting surface of the tooth. It is usually used when the tooth is too damaged to support an Inlay, but not damaged enough to require a Crown.

23. Orthodontics – A dental specialty that treats misalignment of teeth.

24. Periodontal Scaling and Root Planing – The process of removing or eliminating etiologic agents (dental plaque, its products, and calculus) which cause inflammation, and help to maintain disease-free tissues that surround and support the teeth.

25. Prefabricated Stainless Steel Crown – A Crown made of stainless steel that is premanufactured in a variety of sizes and are intended to be fitted upon a child's primary tooth which is damaged, to simulate its original form, decrease the risk of future cavities, save the proper amount of space for the eruption of the permanent tooth, and restore the child's ability to bite and chew.

26. Prosthetic Dentures – Prosthetic devices constructed to replace missing teeth, and which are supported by surrounding soft and hard tissues of the oral cavity. Conventional dentures are removable, however there are many different denture designs, some which rely on bonding or clasping onto teeth or Dental Implants.

27. Provider – A Physician or Dentist, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by UCD. 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. Participating Provider – A Provider that has a Provider Agreement with the United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

    b. Non-Participating Provider – A Provider that does not have a Provider Agreement with the United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

28. Provider Agreement – An agreement for payment contracted by UCD with Participating Providers. These agreements establish the actual payments which will be made to the Participating Provider.

29. Resin-Based Composite – Material composed of plastic with small glass or ceramic particles, which resemble the appearance of natural teeth.

30. Sealant – Plastic material usually applied to the chewing surfaces of the back teeth (premolars and molars) where decay occurs most often, so that they act as a barrier to prevent cavities.

31. Space Maintainer – Besides being useful for chewing, baby teeth also act as a guide for the eruption of the permanent teeth that replaces them. If a baby's tooth is lost too early, the permanent tooth that comes after it loses its guide, so it could drift or erupt into the wrong position in the mouth. Neighboring teeth also can move or tilt into the space, reducing the space available for the permanent tooth to come out. Space

Maintainers are appliances used when a baby tooth is lost too early to help make room for the permanent tooth it was intended to guide.

32. Temporomandibular/Craniomandibular Joint Disorders – 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.

33. UCD – United Concordia Companies, Inc. d/b/a United Concordia Dental, the network and claims administrator for the pediatric dental Benefits in this plan and oral Surgery provided by an Advantage Plus Participating Provider.

B. Diagnostic and Preventive Services

After the Member's payment of the corresponding Deductible and Coinsurance, according to the Schedule of Benefits, this plan will cover:

1. Oral Exams

    a. One (1) periodic, limited problem-focused or comprehensive oral exam every six (6) months.

    b. One (1) detailed problem-focused oral evaluation every six (6) months.

2. Oral Cleanings (Prophylaxis)

    a. Limited to one (1) every six (6) months.

    b. One (1) additional cleaning during the Plan Year will be allowed for Members that are under the care of a medical professional during pregnancy.

3. Fluoride Treatment

    a. Limited to children under nineteen (19) years old; and

    b. Limited to two (2) topical applications every twelve (12) months.

4. Sealants

    a. Limited to children under nineteen (19) years old, and only for permanent first and secondary molars; and

    b. Limited to one (1) per tooth every thirty-six (36) months.

5. Consultations

    Diagnostic services provided by a Dentist or Physician other than practitioner providing the dental treatment.

6. Emergency (Palliative) Treatment

7. Oral Radiographs (X-rays)

    a. Complete series intraoral x-rays or panoramic film x-rays, limited to one (1) film every sixty (60) months and

    b. Bitewing x-rays, limited to one (1) set every six (6) months.

C. Basic Services

1. Space Maintainers

a. Covered when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars or deciduous molars and permanent first molars that have not or will not develop; and

b. Includes coverage for recementation of Space Maintainer.

2. Amalgam Restorations (Metal Fillings)

3. Resin-Based Composite Restorations (White Fillings)

4. Crown Repairs – Recementation, restoration and pin retention

   Recementation that becomes necessary during the first twelve (12) months following insertion by the same Provider is considered to be a part of the original Benefit.

5. Prefabricated Stainless Steel Crowns

   a. Limited to Members under fifteen (15) years old; and

   b. Limited to one (1) per tooth every thirty-six (36) months.

D. Major Services

1. Endodontic (Pulpal) Therapy

   a. Only covered if performed after forty-five (45) days from a root canal, otherwise will be considered part of the root canal.

   b. Limited to primary incisor teeth for Members up to age six (6) and for primary molars and cuspids up to age eleven (11).

   c. Limited to one (1) per eligible tooth per lifetime.

2. Root Canal

3. Surgical Periodontics

   a. Gingivectomy or Gingivoplasty, limited to one (1) every thirty-six (36) months.

   b. Gingival flap procedure, limited to one (1) every thirty-six (36) months.

   c. Clinical Crown lengthening.

   d. Osseous Surgery, limited to one (1) every thirty-six (36) months.

   e. Guided tissue regeneration, limited to one (1) per tooth per lifetime.

   f. Pedicle soft tissue graft, limited to one (1) every thirty-six (36) months.

   g. Free soft tissue graft.

   h. Subepithelial connective tissue graft.

   i. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to one (1) per lifetime.

4. Non-Surgical Periodontics

   Periodontal Scaling and Root Planing, limited to one (1) every twenty-four (24) months for each area of the mouth.

5. Periodontal Maintenance

   Limited to four (4) every twelve (12) months in addition to routine prophylaxis.

6. Simple Extractions

   Extraction of erupted tooth or exposed root.

7. Surgical Extractions

   Surgical removal of erupted tooth with elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

8. Oral Surgery

   a. Removal of impacted tooth.

   b. Surgical removal of residual tooth roots.

   c. Coronectomy-intentional partial tooth removal.

   d. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.

   e. Surgical access to an unerupted tooth.

   f. Alveoloplasty.

   g. Removal of exostosis.

   h. Intraoral soft tissue incision and drainage of abscess

   i. Suture of recent small wounds.

   j. Excision of pericoronal gingiva.

9. Anesthesia

   a. Anesthesia for dental services covered only when Dentally Necessary.

   b. Includes deep sedation/general anesthesia or intra-venous conscious sedation/analgesia.

   c. If the Member has a medical condition that requires dental services which would ordinarily be provided in a dental office to be performed in a Hospital setting, the anesthesia services will be covered exclusively under the medical coverage of this plan and not under this pediatric dental Benefit.

10. Prosthetic Dentures

    a. Includes complete, fixed, removable or partial dentures.

    b. Limited to one (1) every sixty (60) months.

11. Inlays, Onlays and Crowns

    a. Crowns, Inlays, Onlays, core buildup including pins, and prefabricated post and core; and

    b. All limited to one (1) per tooth every sixty (60) months.

12. Adjustments, repairs, and replacement of Prosthetic Dentures

13. Other Prosthetic Services

    a. Rebase or reline of mandibular or maxillary complete or partial dentures, limited to one (1) every thirty-six (36) months. Covered only for six (6) months after the initial installation.

    b. Tissue conditioning.

    c. Recementation or repair of fixed partial denture.

        (1) Recementation during the first twelve (12) months following insertion from the same Dentist is included in the prosthetic service Benefit.

14. Dental Implants

    a. Implants must be Dentally Necessary and are covered only when the arch cannot be restored with a standard prosthesis or restoration.

    b. The following implant Benefits are limited to one (1) every sixty (60) months:

        (1) endosteal, eposteal, and transosteal implants;

        (2) connecting bar;

        (3) prefabricated abutment;

        (4) abutment supported Crowns;

        (5) implant supported Crowns;

        (6) abutment supported retainers for dentures;

        (7) implant supported retainers for dentures;

        (8) implant maintenance procedures;

        (9) repair of implant prosthesis;

        (10) replacement of semi-precision or precision attachment;

        (11) repair of implant abutment;

        (12) implant removal;

        (13) implant index; and

        (14) surgical placement of interim implant body.

    c. Implant supported complete or partial dentures.

15. Occlusal Guard

    a. Limited to one (1) every twelve (12) months; and

    b. Limited to patients that are thirteen (13) years of age and older.

16. Adjunctive General Services

    a. Therapeutic drug injection.

    b. Treatment of Complications from oral Surgery in unusual circumstances (for example, but not limited to, treatment of dry socket following extraction or removal of bony sequestrum).

E. Medically Necessary Orthodontics

Covered Benefits include services for limited, interceptive and comprehensive Orthodontic treatment of the primary, transitional and adolescent dentition in addition to removable and fixed appliance therapy. Treatment visits are provided for pre-Orthodontic, periodic Orthodontic and Orthodontic retention.

Orthodontic services will only be covered if the Member fits the following criteria:

1. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive Orthodontic services.

2. **All Orthodontic services require Authorization,** a written plan of care, and must be rendered by a Provider.

3. Orthodontic treatment must be considered Medically Necessary and be the only method considered capable of:

    a. Preventing irreversible damage to the Member's teeth or their supporting structures.

    b. Restoring the Member's oral structure to health and function.

4. A medically necessary Orthodontic service is an Orthodontic procedure that occurs as a part of an approved Orthodontic treatment plan that is intended to treat a severe dentofacial abnormality or serious handicapping malocclusion. **Orthodontic services for cosmetic purposes are not covered.**

5. Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the Member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.

6. Dentofacial abnormalities that severely compromise the Member's physical health may be manifested by:

    a. Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together.

    b. Under-developed lower jaw and receding chin.

    c. Marked asymmetry of the lower face.

7. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

    a. Obvious difficulty in eating because of the malocclusion, so as to require a liquid or semisoft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.

    b. Obvious severe breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic mouth breathing and postural abnormalities relating to breathing difficulties.

    c. Lisping or other speech articulation errors that are directly related to orofacial abnormalities and cannot be corrected by means other than Orthodontic intervention.

F. Pre-Determination

Pre-determination of dental Benefits is a service available through UCD. This Benefit review in advance of treatment enables You and Your Dentist to see what services are covered by the plan and what Your cost share and other costs would be.

Pre-determination should not be requested unless total charges for a proposed treatment plan exceed $200. You may ask Your Dentist to submit a pre-determination request. UCD will then provide a summary of covered expenses and payable amounts.

Please note that pre-determinations are not designed to be used for Emergency treatments or routine preventive services such as exams, x-rays or cleanings.

A pre-determination is not an Authorization. When a Covered Service needs to be Authorized, a formal Authorization request before service will have to be submitted.

G. Alternate Benefits

If UCD determines that a less costly Covered Service other than the Covered Service the Dentist performed could have been performed to treat a dental condition, We will pay Benefits based upon the less costly service if such service would produce a professionally acceptable result under generally accepted dental standards. If the Member and the Dentist choose the more expensive treatment, the Member will be responsible for the additional charges, beyond those allowed under this clause. This limitation does not apply to covered implantology services.

Alternate Benefits applicable to Your treatment plan will be determined during Authorization. However, should the services billed differ from those Authorized, UCD reserves the right to determine if an alternate Benefit applicable to the actual services rendered.

H. Coordination of this Section with Stand-Alone Dental Contracts

If a Member has stand-alone coverage for dental Benefits that includes coverage for the Benefits provided for under this plan, the dental Benefits under the stand-alone coverage will be determined first. Then, the Benefits under this section will be determined on a secondary basis and will be reduced, so that no more than the full amount of the Allowable Charge is paid under all the dental Benefits for the same Claim or service.

I. Benefit Extension Period After Termination of Coverage

1. The dental coverage under this section will be extended after the date the coverage for the Member terminates only if:

    a. A covered Benefit for such service was incurred while coverage was in effect; and

    b. Such covered Benefit is completed within thirty-one (31) days after coverage terminates.

2. A covered Benefit expense will be deemed incurred as follows:

    a. For appliances or changes to appliances – on the date the appliance or prosthesis is permanently placed;

    b. For Crowns, dentures or bridgework – on the date the impression is taken;

    c. For root canal therapy – on the date the pulp chamber is opened; or

    d. For all other dental expenses – on the date the service is rendered or the supply is furnished.

J. Exclusions

Only American Dental Association procedure codes are covered under this section. Except as specifically provided in this plan and Schedule of Benefits, no coverage will be provided under this section for services, supplies or charges that are:

1. Started prior to the Member's Effective Date or after the termination date of coverage under this plan including, but not limited to, multi-visit procedures such as endodontics, Crowns, bridges, Inlays, Onlays, and dentures.

2. For house or Hospital calls for dental services and for hospitalization costs (e.g., facility-use fees).

3. The responsibility of any federal or state workers' compensation laws and/or related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes, whether or not coverage under such laws or programs is actually in force, the responsibility of employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. Benefits would be in excess of the third-party Benefits and therefore, We would have right of recovery for any Benefits paid in excess. Our right of subrogation is secondary to the right of the covered insured to be fully compensated for his damages.

4. Cosmetic in nature as determined by UCD (for example, but not limited to, bleaching, veneer facings, personalization or characterization of Crowns, bridges and/or dentures).

5. Maxillofacial prosthetics.

6. Elective procedures (for example, but not limited to, the prophylactic extraction of third molars).

7. For congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to Cleft Lip or Cleft Palate, disharmony of facial bone, or required as the result of orthognathic Surgery including Orthodontic treatment). Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies or Equipment Article of this plan.

8. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under this plan. Examples of these jaw joint problems are temporomandibular joint disorders and craniomandibular disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint.

9. For treatment of fractures and dislocations of the jaw.

10. For treatment of malignancies or neoplasms.

11. For services and/or appliances that alter the vertical dimension (for example, but not limited to, full-mouth rehabilitation, splinting, Fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

12. For replacement or repair of lost, stolen or damaged prosthetic or Orthodontic appliances.

13. For periodontal splinting of teeth by any method.

14. For duplicate dentures, prosthetic devices or any other duplicative device.

15. For which in the absence of insurance the Member would incur no charge.

16. For plaque control programs, oral hygiene and dietary instructions.

17. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

18. For treatment and appliances for bruxism (night grinding of teeth), with exception of an Occlusal Guard.

19. For any Claims submitted to the Company or UCD later than fifteen (15) months after the date of service.

20. For incomplete treatment (for example, but not limited to, patient does not return to complete treatment) and temporary services (for example, but not limited to, temporary restorations).

21. For procedures that are:

    a. part of a service but are reported as separate services; or

    b. reported in a treatment sequence that is not appropriate; or

    c. misreported or that represent a procedure other than the one reported.

22. For specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).

23. Fees for broken appointments.

24. Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of UCD will apply.

25. Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and a written treatment plan is approved by Us. Orthodontic services for the following are excluded:

    a. Treatments that are primarily for Cosmetic reasons.

    b. Treatments for congenital mouth malformations or skeletal imbalances (e.g., treatment related to Cleft Lip or Cleft Palate, disharmony of facial bone, or required as the result of orthognathic Surgery including Orthodontic treatment). Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies or Equipment Article of this plan.

    c. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Schedule of Benefits. Examples of these jaw joint problems are temporomandibular joint disorders and craniomandibular disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint.

26. Posterior resin Fillings.

27. Administration of nitrous oxide.

ARTICLE XVI. PEDIATRIC VISION CARE BENEFITS

The vision Benefits described in this section are available for Members under the age of nineteen (19) only.

Members who attain age nineteen (19) during a Plan Year will continue to have these Benefits until the end of that Plan Year. The Schedule of Benefits controls the Benefits covered, the frequency with which they are covered, and the cost sharing applicable to each Benefit. The Benefits offered are limited.

A. Definitions *(Applicable only to this Pediatric Vision Care Benefits Article of this plan)*

1. Bifocal Lenses – A lens containing two different powers: one for distance vision and one for near vision. Bifocal Lenses can be lined or unlined. Lined Bifocal Lenses are those in which both powers are easily distinguished by a line between them. Unlined Bifocal Lenses are those in which both powers are not easily distinguishable.

2. Blended-Segment Lenses – A lens containing two different powers, one for distance, and one for near. Segment with near prescription is invisible.

3. Company – HMO Louisiana, Inc. or Davis Vision, Inc. in regards to the services it renders on HMO Louisiana, Inc.'s behalf.

4. Contact Lenses – Devices that correct refractive errors in vision and are comprised of a small shell-like lens that is worn externally resting directly on the eye. To include soft lens, daily wear, disposable/planned replacement, extended wear, gas permeable, hard, Medically Necessary, monovision, scleral shell, and toric.

5. Digital Surface Technology Progressive Lenses – A lens that is designed to provide correction for more than one viewing range, in which the power changes continuously rather than discretely. The digital surfacing technology refers to a digital manufacturing technique that uses proprietary software to define a unique progressive lens fully customized to the wearer's prescription, fitting geometry and frame information before cutting this design into the lens.

6. Evaluation and Fitting – Means the professional individualized fitting of Contact Lenses and the professional evaluation to check that the prescription is correct and that there is no irritation of the eyes.

7. Eyeglass Frame – Plastic or metal structure for holding Spectacle Lenses.

8. Fashion Tinting – Tints that are used primarily for cosmetic purposes.

9. Glass-Grey #3 Prescription Sunglass Lenses – Glass lenses that turn grey when exposed to the sun's ultraviolet light.

10. Gradient Tinting – A Spectacle Lens coating that is darker at the top of the lens, fading to lighter at the bottom.

11. High-Index Lenses – Material that results in thinner (almost one-third) Spectacle Lenses than normal plastic. Does not contain the impact resistant qualities of polycarbonate.

12. Intermediate-Vision Lens – A Trifocal Lens or blank which has been designed to correct vision at ranges intermediate to distant and near objects.

13. Lenticular Lenses – A lens, usually of strong refractive power, in which the prescribed power is applied over only a limited central region of the lens, called the lenticular portion.

14. Medically Necessary Contact Lenses – Contact Lenses that are determined as Medically Necessary in the treatment of the following conditions: Keratoconus, Anisometropia, Corneal Disorders, Pathological Myopia, Aniseikonia, Post-Traumatic Disorders, Aphakia, Aniridia and Irregular Astigmatism. In general, Medically Necessary Contact Lenses may be prescribed in lieu of eyeglasses, when it will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

15. Monocular Patient – Refers to a patient who sees out of only one eye.

16. Oversize Lenses – A larger than standard lens type that requires special frames and equipment to fabricate the eyeglasses.

17. Pediatric Contact Lenses Selection or Selection Contact Lenses – A selection of Contact Lenses offered to Members by Davis Vision through Participating Providers.

18. Pediatric Eyeglass Frames Selection or Selection Frames – A selection of Eyeglass Frames offered to Members by Davis Vision thorough Participating Providers.

19. Photochromic Glass Lenses – Glass Spectacle Lenses that darken when exposed to the ultraviolet rays of the sun.

20. Plastic Photosensitive Lenses – Plastic lenses that darken when exposed to the sun's ultraviolet rays.

21. Polarized Lenses – Spectacle Lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

22. Polycarbonate Lens – A Spectacle Lens made of a high impact-resistant material used for safety in children's eyewear, sports and other cosmetic purposes. Lenses are 20-25% thinner than regular plastic.

23. Premium Anti-Reflective Coating – A non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection with superior smudge resistance and optimum clean-ability, such as Crizal™ or equivalent. Advanced forms of Anti-Reflective Coatings for Spectacle Lenses with improved durability.

24. Premium Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with a newer, branded progressive lens design or a proprietary, digitally manufactured design. Lenses are often referred to as free-form design or wave-front technology to help minimize peripheral distortion.

25. Provider – An ophthalmologist, optometrist, optician, Physician, or legally authorized eyeglass and contact lens retail store, licensed where required, performing within the scope of license, and approved by the Company. 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. Participating Provider – A Provider that has a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member.

    b. Non-Participating Provider – A Provider that does not have a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member.

26. Routine Eye Health Examination – A level of service in which a general evaluation of the complete visual system of the human body is made. This includes:

    a. Case history (chief complaint, eye and vision history, medical history);

    b. Entrance distance and near acuities, with and without current lenses;

    c. External ocular evaluation;

    d. Internal ocular examination;

    e. Tonometry;

    f. Refraction (objective and subjective);

    g. Binocular coordination and ocular motility evaluation;

    h. Evaluation of pupillary function;

    i. Biomicroscopy;

    j. Gross visual fields;

    k. Assessment and plan;

    l. Advising the patient on matters pertaining to vision care;

    m. Form completion (e.g., school, motor vehicle); and

n. A Dilated Fundus Examination (DFE) when professionally indicated (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systematic diseases).

27. Scratch Protection Plan – An optional plan that will replace scratched lenses with new lenses of the same material, style and prescription, at no charge for a period of one (1) year from the original date of dispensing. A Scratch Protection Plan may be available for single vision lenses only, for multifocal vision lenses only, or for both.

28. Scratch-Resistant Coating – Coating applied to Spectacle Lenses to increase the scratch resistance of the lens surface.

29. Select Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with a newer, proprietary progressive lens design.

30. Specialty Type Contact Lenses – Contact Lenses that are newer in the market than Standard Type Contact Lenses and require a specialty fitting. These lens types include, but not limited to, toric, multifocal and gas permeable lenses.

31. Spectacle Lenses – Devices that correct refractive errors in vision which are intended to be mounted on Eyeglass Frames to be worn externally, involving a transparent medium bounded by two geometrically describable surfaces one of which shall be curved, that is, spherical, cylindrical, toroidal, or aspheric.

32. Standard Anti-Reflective Coating – A non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection, such as Aegis™ Anti-Reflective Treatment or equivalent.

33. Standard Progressive Lenses – Lenses with variable power zones from far distance to near distance correction with an older, proven branded progressive lens design.

34. Standard Type Contact Lenses – Commonly used Contact Lens types defined as spherical clear Contact Lenses. These include disposable Contact Lenses planned replacement lenses and others.

35. Trifocal Lenses – A multifocal lens with three different powers in three different positions. Usually, the top (largest) portion is for distance vision, the middle portion is for intermediate distances and the bottom portion is for near vision. Trifocal Lenses can be lined or unlined. Lined Trifocal Lenses are those in which the different powers are easily distinguished by a line between them. Unlined Trifocal Lenses are those in which the different powers are not easily distinguishable.

36. Ultra Anti-Reflective Coating – Non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection. The ultra-coating uses the latest lens material technologies with all the Benefits of both standard and premium lenses.

37. Ultra Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with the newest branded progressive lens design technology, including a digitally manufactured design.

38. Ultraviolet Coating – A coating for Spectacle Lenses that blocks ultraviolet rays.

B. Vision Benefits

The Schedule of Benefits will control how the Benefits described in this section are covered under the Member's plan, with what frequency, and what limitations apply to them. Please refer to the Schedule of Benefits for details.

1. Network Benefits

   Subject to the specifications described on the *Schedule of Benefits*, each Member will have coverage for the following services, if received from Participating Providers:

a. One (1) Routine Eye Health Examination

The Company will cover one (1) Routine Eye Health Examination as stated on the *Schedule of Benefits*. Covered Routine Eye Health Examinations will include dilation of eye pupils when professionally indicated.

b. Prescription Spectacle Lenses for each of the Member's Eyes

The Company will cover one (1) prescription Spectacle Lens for each of Member's eyes, as stated on the Schedule of Benefits. The Schedule of Benefits explain if the Member has additional coverage for some special types of lens material and enhancements, and the Copayment that applies to each. Lens materials or enhancements not specifically mentioned on the Schedule of Benefits are not covered.

c. Pediatric Eyeglass Frame Selection

The Company will cover one (1) Selection Frame as stated on the Schedule of Benefits. Participating Providers will show the Member the selection of frames covered by this plan. If the Member does not select a Selection Frame, he will be responsible for the difference in cost between the Selection and Non-Selection Frame. Any amount paid to the Provider for the difference in cost of a Non-Selection Frame is not covered and will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket Amount. Any frame purchased from a Non-Participating Provider will be considered a Non-Selection Frame and will be subject to the Non-Network Benefit limitations.

d. Prescription Pediatric Contact Lenses Selection

The Company will cover Prescription Selection Contact Lenses, in lieu of eyeglasses, and up to the maximum of pairs or boxes for conventional or planned replacement Contact Lenses stated on the Schedule of Benefits. Participating Providers will inform the Member of the Contact Lenses selection covered by this plan. If the Member chooses Non-Selection Contact Lenses, he will be responsible the difference in cost between the Selection and Non-Selection Contact Lenses. Any amount paid to the Provider for the difference in cost of a Non-Selection Contact Lens is not covered and will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket Amount. Any Contact Lens purchased from a Non-Participating Provider will be considered a Non-Selection Contact Lens, and coverage will be limited according to the Non-Network Benefit section.

e. Low Vision Benefits

Subject to prior Authorization, Members with Low Vision will receive the following:

(1) One (1) comprehensive evaluation every five (5) years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

(2) One (1) device per year such as high-power spectacles, magnifiers and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs.

(3) Four (4) follow-up visits in any five (5) year period.

C. Limitations to Network Benefits

1. Medically Necessary Contact Lenses

Medically Necessary Contact Lenses are subject to Authorization. Medically Necessary Contact Lenses that are not duly Authorized will not be covered.

2. Selection and Non-Selection Eyeglass Frames

Members may choose either one (1) Selection or one (1) Non-Selection Eyeglass Frame within their frequency period, but not both.

3. Contact Lens Evaluation, Fitting and Follow-up Care

   Evaluation and Fitting services for Selection Contact Lenses and Medically Necessary Contact Lenses that are provided by a Participating Provider are covered. Follow-up services are covered up to one (1) visit only. Evaluation, Fitting and follow-up services for Non-Selection Contact Lenses are not covered.

D. Non- Network Benefits

This plan does not provide coverage for services and materials rendered by Non-Participating Providers. Any charges billed by Non-Participating Providers for those services will not be covered and will be the responsibility of the Member.

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

E. Discounts

Members may have access to discounts on vision-related services and materials not covered under this plan. Any discounts are administered and provided by Davis Vision in consideration of the Member being covered under this plan. Discounts are not to be considered coverage under this plan, unless stated otherwise in the materials describing the discount. Davis Vision may change or discontinue the discounts provided to their clients in the regular course of business. Members must consult with Davis Vision or a Davis Vision Provider to find out what discounts are available to them at any specific time.

F. Sales Taxes on Covered Items

Providers may be required in some areas to collect sales taxes over the value of covered items or services. In such cases, this coverage will not cover sales taxes. The Member must pay any sales taxes, in addition to non-covered amounts and discount priced items.

G. Exclusions

1. Implants**,** intacts or any kind of intraocular lenses.

2. Surgical treatments for vision correction, unless otherwise specifically covered under another part of this plan.

3. Services or materials other than those specifically listed on the Schedule of Benefits for Vision Care and described under this part of this plan.

4. Non-prescription eyewear or Contact Lenses.

5. Any sales taxes or interest.

ARTICLE XVII. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following Benefits are available to You, subject to other limitations shown on 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 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 treating 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 condition 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 diagnostic or therapeutic Outpatient 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 Services must be specifically requested by police or medical authorities present at the site with You 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

Benefits for non-Emergency air Ambulance Services must be Authorized by Us before services are rendered or no Benefits are available for the services. 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 Your 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 where the pick-up is to occur, based on the zip code where You are picked up. 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 We do 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 a Provider agreement is in effect between Us 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. You must pay the Copayment, Deductible Amount, and Coinsurance that apply to the type of Provider rendering services for this condition.

C. Autism Spectrum Disorders

Autism Spectrum Disorder Benefits include, but are not limited to, the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Habilitative and Rehabilitative Care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Applied Behavior Analysis is available for coverage of the treatment of Autism Spectrum Disorders when it is determined to be Medically Necessary.

Autism Spectrum Disorder Benefits are subject to the Copayments, Deductible Amounts, and Coinsurance that are applicable to the Benefits obtained. Example: A Member obtains speech therapy for treatment of Autism Spectrum Disorders. The Member will pay the applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

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

1. Under the Women's Health and Cancer Rights Act, a Member who is receiving Benefits in connection with a mastectomy and elects breast reconstruction will also receive Benefits for the following Covered Services:

a. All stages of reconstruction of the breast on which the mastectomy has been performed or reconstruction of both breasts if a bilateral mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomy, 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 lymphedemas.

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

E. Cleft Lip and Cleft Palate Services

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

1. oral and facial Surgery, surgical management, and follow-up care;

2. prosthetic treatment, such as obturators, speech appliances, and feeding appliances;

3. orthodontic treatment and management;

4. preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy;

5. Speech/Language evaluation and therapy;

6. audiological assessments and amplification devices;

7. otolaryngology treatment and management;

8. psychological assessment and counseling; 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.

F. Clinical Trial Participation

1. This Contract covers any Qualified Individual for routine patient costs of items or services furnished to participate in an Approved Clinical Trial for cancer or other Life-Threatening Illness. Coverage will be subject to any terms, conditions, and limitations that apply under this Contract, including Copayments, Deductible Amounts, and Coinsurance shown on the *Schedule of Benefits*.

2. A Qualified Individual under this section means a Member that:

    a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol for treating cancer or other Life-Threatening Illness;

    b. And either,

        (1) The referring healthcare professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or

        (2) The Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate based upon the Member meeting the conditions described in paragraph a, above.

3. An Approved Clinical Trial for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to prevent, detect, or treat cancer or other Life-Threatening Illness that:

    a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

        (1) The National Institutes of Health.

        (2) The Centers for Disease Control and Prevention.

        (3) The Agency for Health Care Research and Quality.

        (4) The Centers for Medicare & Medicaid Services.

        (5) Cooperative group or center of any of the entities described in paragraphs (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

        (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

    b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

    c. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

    d. The study or investigation is conducted by any of the below Departments, which study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

        (1) The Department of Veterans Affairs.

        (2) The Department of Defense.

        (3) The Department of Energy.

4. 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. The investigational drugs, devices, items or services themselves; and

d. Services, treatment or supplies not otherwise covered under this Contract.

5. Treatments and associated protocol-related patient care not excluded in this paragraph will 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 other Life-Threatening Illness or for the prevention or early detection of such diseases.

   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.

   c. 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.

   d. 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.

   e. There must be no clearly superior, non-investigational approach.

   f. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.

   g. The patient has signed an institutional review board approved consent form.

G. 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 the 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 who certifies that You have successfully completed the training program.

      (2) The program will 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.

H. Dietitian Visits

Benefits are available for Outpatient 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 services of a Dietitian should receive those services as part of their Benefits for Diabetes Education and Training for Self- Management.

I. Disposable Medical Equipment and Supplies

Disposable medical equipment and 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 Amount and Coinsurance.

J. Durable Medical Equipment, Orthotic Devices, Prosthetic Appliances and Devices

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Deductible Amount and Coinsurance shown on the Schedule of Benefits.

1. Durable Medical Equipment

   a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician and Authorized by Us before obtaining the equipment. The equipment must not be provided mainly for comfort or convenience. In addition, the equipment must meet all of the following criteria:

      (1) It must withstand repeated use;

      (2) It is primarily and customarily used to serve a medical purpose;

      (3) It is generally not useful to a person in the absence of illness or injury; and

      (4) It is appropriate for use in the patient's home.

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

      (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not more than 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) When a Durable Medical Equipment is approved by Us, Benefits for standard equipment will be provided toward any deluxe equipment.

         Deluxe equipment or deluxe features and functionalities of equipment are those:

         (a) that do not serve a medical purpose;

         (b) that are not required to complete daily living activities;

         (c) that are solely for Your comfort or convenience; or

         (d) that are not determined by Us to be Medically Necessary.

      (4) 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.

      (5) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement of equipment lost, or replacement of equipment damaged due to neglect or misuse will not be covered. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Contract, will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment subject to a recall within five (5) years after purchase or rental will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

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

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

(5) Regardless of Claims of Medical Necessity, deluxe equipment or deluxe features and functionalities of equipment that are not approved by Us are not covered.

2. Orthotic Devices

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

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

b. Repair or replacement of the Orthotic Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the device. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of the device will not be covered when provided under warranty or when the device is subject to a recall.

c. When Orthotic Devices are approved by Us, Benefits for standard devices will be provided toward any deluxe device.

(1) Deluxe devices or deluxe features and functionalities of devices are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for Your comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

(2) Regardless of Claims of Medical Necessity, deluxe devices or deluxe features and functionalities of devices that are not approved by Us are not covered.

d. No Benefits are available for supportive devices for the foot, except when used in treating diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

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

a. There is no coverage for fitting or adjustments, as these are 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. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.

c. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or device.

(1) Deluxe appliances or devices or deluxe features and functionalities of appliances or devices are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for Your comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

(2) Regardless of Claims of Medical Necessity, deluxe appliances or devices or deluxe features and functionalities of appliances or devices that are not approved by Us are not covered.

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

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

a. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.

b. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or device.

(1) Deluxe appliances or devices or deluxe features and functionalities of appliances or devices are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for Your comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

(2) Regardless of Claims of Medical Necessity, deluxe appliances or devices or deluxe features and functionalities of appliances or devices that are not approved by Us are not covered.

c. You 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 appliance or device and the Benefit payable, without financial or contractual penalty to the Provider of the appliance or device.

d. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

K. 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.

L. 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 THE COMPANY PRIOR TO SERVICES BEING PERFORMED; AND

2. SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM THE COMPANY TO PERFORM YOUR PROCEDURE.

M. Genetic or Molecular Testing for Cancer

Genetic or molecular testing for cancer are covered under this Contract as required by law and when Medically Necessary.

N. Hearing Benefits

1. Hearing Benefits for Members age 17 and under

   Benefits are available for hearing aids for Member's age seventeen (17) and under when obtained from a Network Provider. This Benefit is limited to one (1) hearing aid for each ear with hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or licensed hearing aid dealer after the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

   This Benefit is subject to payment of the applicable Copayment, Deductible Amount and Coinsurance.

2. Hearing Benefits for Members age 18 and older

   Benefits are available for hearing aids for covered Members age eighteen (18) and older for severe hearing loss or profound hearing loss and when obtained from a Network Provider. Severe hearing loss or profound hearing loss is defined as hearing loss of 71dB or higher. This Benefit is limited to one (1) hearing aid for each ear with severe hearing loss or profound hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate for the Member.

   If more than one type of hearing aid can meet the Member's functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for the Member's needs. If the Member purchases a hearing aid that exceeds these minimum specifications, We will only pay the amount that We would have paid

for the hearing aid that meets the minimum specifications, and the Member will be responsible for paying any difference in cost, without financial or contractual penalty to the Provider of the hearing aid.

Authorization must be obtained prior to receiving a hearing aid for Members who are age eighteen (18) and older. This Benefit is subject to Medical Necessity and payment of the applicable Copayment, Deductible Amount and Coinsurance.

3. Cochlear Implants and Bone Anchored Hearing Aids (BAHA)

Benefits are available for cochlear implants and bone-anchored hearing aids (BAHA) for all eligible Members with severe hearing loss or profound hearing loss, regardless of age, the same as any other service or supply.

This Benefit is subject to Medical Necessity and payment of the applicable Copayment, Deductible Amount and Coinsurance.

4. Limitations in Connection with Hearing Aids or Other Hearing Devices

Benefits for hearing aids, assistive listening devices or other devices available over-the-counter (OTC) are not covered.

Benefits for hearing aids or other hearing devices are not covered if We determine that a hearing aid, assistive listening device or other hearing device that is available over-the-counter is a clinically appropriate or suitable treatment for a Member's hearing loss.

Replacement of hearing aids and other hearing devices that are lost or damaged due to neglect or misuse are not covered.

Repair, adjustment, or replacement of hearing aids or other hearing devices are not covered when provided under warranty or when the hearing aid or other hearing devices are subject to a recall.

Hearing aid repairs and supplies are not covered when provided by a Non-Network Provider. This limitation does not apply to Cochlear Implants or BAHA.

O. High-Tech Imaging Services

Your Contract covers Medically Necessary High-Tech Imaging Services, including, but not limited to MRIs, MRAs, CT scans, PET scans, and nuclear cardiology. We must Authorize these services before You receive them.

P. Home Health Care

Home Health Care services provided to a Member instead of an Inpatient Hospital Admission are covered.

Q. Hospice Care

Hospice Care is covered.

R. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter or transliterator 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. These services are not covered if rendered by a family member, or if the medical treatment or diagnostic consultation is not covered.

S. Low-Protein Food Products for Treating Inherited Metabolic Diseases

Low-protein food products for treating certain Inherited Metabolic Diseases are covered. Inherited Metabolic Diseases are diseases caused by an inherited abnormality of body chemistry. Low-Protein Food Products are foods that are especially formulated to have less than 1 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 do not include natural foods that are naturally low in protein.

Benefits for Low-Protein Food Products are limited to treating the following diseases:

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia

T. 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 multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

U. Out of Area Emergency Medical Services

1. You must pay an Emergency Room Copayment, Deductible Amount, and Coinsurance as shown on the Schedule of Benefits, for each visit You make to a Hospital or Allied Health Facility for Emergency Medical Services while outside Your Service Area.
2. The Emergency Room Copayment is waived if the visit results in an Inpatient Hospital Admission.
3. You must pay a Physician Copayment for each visit You make to a Physician office for Emergency Medical Services while outside Your Service Area.

V. Permanent Sterilization Procedures

Coverage is available for surgical procedures that result in permanent sterilization, including vasectomy, tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes. Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are available as a Preventive or Wellness Care Benefit when Covered Services are provided by a Blue Connect Network Provider.

W. Prescription Donor Human Breast Milk

Benefits are available for Medically Necessary pasteurized donor human breast milk prescribed for a Dependent infant, until one (1) year of age, undergoing Inpatient care or Outpatient care who is medically or physically unable to receive maternal human milk or participate in breastfeeding or whose mother is medically or physically unable to produce maternal human milk in sufficient quantities. This coverage is limited to a two-month supply per infant per lifetime and is limited to prescribed donor human breast milk obtained from a member bank of the Human Milk Banking Association of North America or other source approved by Us.

X. Prescription Drugs

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.

Y. Private Duty Nursing Services

1. Your Contract covers Private Duty Nursing Services when they are performed on an Outpatient basis and when the nurse is not related to You by blood, marriage or adoption.

2. Your Contract covers Private Duty Nursing Services subject to the Deductible Amount and Coinsurance shown on the Schedule of Benefits.

3. Your Contract does not pay for Inpatient Private Duty Nursing Services.

4. Your Contract limits coverage for Private Duty Nursing Services to four hundred (400) hours per Benefit Period.

Z. 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. Check Your Provider directory or call customer service at the number on the ID card to verify that a sleep laboratory is accredited.

AA. Telehealth Services and Remote Patient Therapy 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. Interaction between Member and Provider may take place in different ways, depending on the circumstances, but this interaction must always be suitable for the setting in which the Telehealth Services and Remote Patient Therapy services are provided. Telehealth Services generally must be held in real time by two-way video and audio transmissions simultaneously (Synchronous). Telehealth Services does not cover telephone calls, and only when approved by Us is it allowed by methods other than simultaneous audio and video transmission.

Store Forward or Asynchronous Telehealth Services between an established patient and their Provider may take place when an established patient sends pre-recorded video or images to a Provider via HIPAA-compliant communication, 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 limited to services approved by Us.

Store Forward or Asynchronous Remote Patient Therapy services between an established patient and a Provider who has an established, documented, and ongoing relationship with the patient may take place when an established patient uses an FDA-approved or FDA-authorized device to collect and electronically transmit biometric data to a Provider to be analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. This method of Remote Patient Therapy services is limited to services and devices approved by Us.

In order to be covered, Remote Patient Therapy services must specifically be required for medical treatment decisions for the Member or as otherwise required by law and must collect and electronically transmit biometric data to an established Provider on at least sixteen (16) days of a thirty-day (30) period.

Unless prohibited by applicable law, the amount You pay for a Telehealth Services visit or Remote Patient Therapy services visit may be different than the amount You would pay for the same Provider's service in a non-Telehealth or non-Remote Patient Therapy setting. You will pay more for a Telehealth visit or a Remote Patient Therapy visit when your Provider is not in your Network.

We have the right to determine if billing was appropriate and contains the required elements for Us to process the Claim.

In general, there is not coverage for Telehealth Services or Remote Patient Therapy services that are not within the scope of the Provider's license or fail to meet any standard of care compared to an in-person visit. Coverage does not exist for non-HIPAA compliant encounters which do not provide a system of secure communication to safeguard protected health information.

Telehealth Services, Remote Patient Therapy services, and the Providers who can render those services are determined by Us.

ARTICLE XVIII. CARE MANAGEMENT

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

1. Authorization and Selection of Provider

   Benefits will be paid at the highest Network level when care is received from a Network Provider.

   a. If a Member wants to receive services from a Non-Network Provider and obtain Network Benefits, he must notify Our care management department before services are rendered. We will approve the use of a Non-Network Provider only if We determine that the services **cannot** be provided by a Network Provider within a 75-mile radius of the Member's home. The Non-Network Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Non-Network Provider.

      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, Deductible Amount and Coinsurance 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, Deductible Amount and Coinsurance whether or not the Copayment, Deductible Amount and Coinsurance 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 before 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 Copayment, Deductible Amount, and Coinsurance shown on the Schedule of Benefits.

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

(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 any Copayment, Deductible Amount, and Coinsurance.

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Member is responsible for ensuring that the Provider notifies Our care management department of any Elective or non-Emergency Inpatient Hospital Admission. We must be notified prior to the Admission regarding the nature and purpose of any Elective Admission or non-Emergency Admission to a Hospital's Inpatient department. To notify Us prior to the Admission, the Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider. The most appropriate setting for the elective service and the appropriate length of stay will be determined by Us when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If a request for Authorization is denied, the Admission is not covered and You 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 Your Physician or Hospital, or a representative thereof, notifies Our care management department of all Emergency Admissions. Within forty-eight (48) hours of the Emergency Admission, We must be notified regarding the nature and purpose of the Emergency Admission. The facility or Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the facility or Provider. We may waive or extend this time limitation if We determine that the Member is unable to timely notify or direct Your representative to notify Us of the Emergency Admission. In the event, the end of the notification period falls on a holiday or weekend, We must be notified on the next working day. The appropriate length of stay for the Emergency Admission will be determined by Us when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If Authorization is denied, the Admission will not be covered and You must pay all charges incurred during the Admission.

(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 Your 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 Us 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 Authorize 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. To request Concurrent Review for Authorization of additional days, the Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider.

(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 before 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 on the Member's Schedule of Benefits. The Member is responsible for making sure his Provider obtains all required Authorizations for him before the Member 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 prior Authorizations, the Member's Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider.

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 – 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 to manage Your chronic disease, establish realistic goals for lifestyle modification, and improve adherence to Your Physician prescribed treatment plan. HMO Louisiana, Inc. is dedicated to supporting the Physician 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 Your particular medical condition renders You a suitable candidate for Case Management services will not obligate Us to make the same or similar determination for any other covered person. 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 this Contract according to its express terms.

4. Unless We expressly agree, all terms and conditions of this Contract, including maximum Benefit limitations and all other limitations and exclusions, will be and remain in full force and effect for a Member who is 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 Us.

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 according to its express terms.

3. Unless expressly agreed upon by Us, all terms and conditions of this Contract, including maximum Benefit limitations and all other limitations and exclusions, will be and will remain in full force and effect if You are receiving Alternative Benefits.

4. Alternative Benefits provided under the article are provided instead of the Benefits to which You are entitled under this Contract and accrue to the maximum Benefit limitations under this Contract.

5. The Member's Alternative Benefits 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 Alternative Benefits or that the Alternative Benefits are no longer necessary.

    b. You receive care, treatment, services, or supplies for the medical condition that this Contract does not cover, and that are not specified as Alternative Benefits that We approve.

ARTICLE XIX. LIMITATIONS AND EXCLUSIONS

A. This Contract Does Not Cover Certain Services, Supplies, and Treatments

Benefits for conditions, services, surgery, supplies and treatment for services that are not covered under this Contract are excluded.

If a Member has Complications from excluded conditions, Surgery, or treatments; Benefits for such conditions, services, surgery, supplies and treatment are excluded.

B. We May Delete or Revise Limitations and Exclusions in this Contract

Any of the limitations and exclusions listed in this Contract may be deleted or revised as shown on the Schedule of Benefits.

Unless otherwise shown as covered on the Schedule of Benefits, the following are excluded:

1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary, as defined in this Contract. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.

2. Any charges more than the Allowable Charge.

3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Services, Surgery, supplies, treatment, or expenses:

    a. other than those specifically listed as covered by this Contract or for which a Member has no obligation to pay, or for which no charge or a lesser charge would be made if a Member had no health insurance coverage (Benefits are available when Covered Services are rendered at medical facilities owned and operated by the State of Louisiana or any of its political subdivisions);

    b. rendered or furnished before the Member's Effective Date or after the Member's coverage terminates, except as follows: Medical Benefits in connection with an Inpatient Hospital Admission will be provided for an Admission in progress on the date a Member's coverage under this Contract ends, until the end of that Admission or until a Member has reached any Benefit limitations set in this Contract, whichever occurs first;

    c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;

    d. to the extent payment has been made or is available under any other Contract issued by 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 according to Our policies and procedures;

    f. rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs, including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes whether or not coverage under such laws or programs is actually in force;

g. received from a dental, vision, or medical department or clinic maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust, or similar person or group;

h. rendered, prescribed, or otherwise provided by a Provider who is the Member, the Member's Spouse, child, stepchild, parent, stepparent or grandparent;

i. for 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; for services billed with Telehealth codes not suitable for the setting in which the services are provided; for Telehealth Services not permitted by Us; and for Telehealth Services rendered by Providers not permitted by Us;

j. for Remote Patient Therapy services and devices unless the results are specifically required for a medical treatment decision for a Member or as required by law;

k. 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 our enrollment in or with any Provider;

l. for services performed in the home unless the services meet the definition of Home Health, or otherwise covered specifically in this Contract, or are approved by Us;

m. for any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Contract; or

n. for paternity tests and tests 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. for treating any Member detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention; and

e. 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), as amended. 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 for Emergency Medical Services.

6. **REGARDLESS OF CLAIMS 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 or re-implantation of breast implants and services, illnesses, conditions, Complications or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Contract;

f. implantation, removal or re-implantation of penile prosthesis and services, illnesses, conditions, Complications 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 Contract. Some of these programs may be offered as value-added services and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs;

j. wilderness camp/programs except when provided by a qualified Residential Treatment Center and approved by Us as Medically Necessary for the treatment of mental health conditions or substance use disorders;

k. treatment related to erectile or sexual dysfunctions, low sexual desire disorder or other sexual inadequacies;

l. industrial testing or self-help programs including stress management programs, work-hardening programs and functional-capacity evaluations; driving evaluations, etc., except services required to be covered by law;

m. recreational therapy;

n. Inpatient pain rehabilitation or Inpatient pain control programs; and

o. primarily to enhance athletic abilities.

7. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses related to:

a. routine eye exams (except for those for diabetics shown in the Benefits section), eyeglasses or Contact Lenses (except for the initial pair and fitting of eyeglasses or Contact Lenses required after cataract Surgery), unless shown as covered in this Contract or on 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 hair implants;

e. the correction of refractive errors of the eye, including radial keratotomy and laser surgery; or

f. visual therapy.

8. **REGARDLESS OF CLAIMS 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;

c. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;

d. the transplant of any non-human organ or tissue; or

e. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Contract.

f. 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 the Company prior to services being rendered.

9. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for any of the following, except as specifically provided for in this Contract or on 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 or services at a health spa or similar facility; or

   d. obesity or morbid obesity, except as required by law.

10. **REGARDLESS OF CLAIMS 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 or prescription donor human breast milk as described in this Contract.

11. Benefits are excluded for Prescription Drugs that We determine are not Medically Necessary to treat illness or injury. The following are also not covered unless shown as covered on the Schedule of Benefits:

    a. lifestyle-enhancing drugs including, but not limited to, medications used for cosmetic purposes (example.g., Botox®, Renova®, Tri-Luma®), medications used to enhance athletic performance, medications used for effects of aging on the skin, and medications used for hair loss or restoration (example.g., Propecia®, Rogaine®), except for Prescription Drugs approved by Us to treat alopecia areata or alopecia universalis;

    b. medications for obesity, weight loss, weight management, or weight maintenance (e.g., Contrave®, Qsymia®, Saxenda®, Wegovy™);

    c. any medication not proven effective in general medical practice;

    d. 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 treating the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least 2 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;

    e. fertility drugs;

f. nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Services Task Force preventive services recommendations. Low Protein Foods and prescription donor human breast milk are covered as described in this Contract;

g. prescription vitamins not listed as covered in the Prescription Drug Formulary (including, but not limited to Enlyte);

h. drugs that can be lawfully obtained without a Physician's order or that do not require a prescription, including over-the-counter (OTC) drugs, except those required to be covered by law;

i. selected Prescription Drugs for which an OTC-equivalent or for which a similar alternative exists as an OTC medication;

j. refills that are more than the number specified by the Physician or the dispensing limitation described in this Contract, or a refill before 75% of day supply used, or any refills dispensed more than 1 year after the date of the Physician original prescription;

k. compounded drugs that exhibit any of the following characteristics:

(1) are similar to a commercially available product;

(2) whose principal ingredients are being used for an indication for which no FDA approval exists;

(3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA-approved labeling (for example, 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;

l. selected Prescription Drug products that contain more than one active ingredient (sometimes called combination drugs);

m. Prescription Drug products that include or are packaged with a non-Prescription Drug product are excluded;

n. Prescription Drug compounding kits are excluded;

o. selected Prescription Drug products that are packaged in a way that contains more than one (1) Prescription Drug;

p. selected Prescription Drug products with multiple therapeutic alternatives, which may be available in a greater or lesser strength or different dosage form (e.g., tablet, capsule, liquid, suspension, extended release, tamper resistant);

q. Prescription Drug products that contain marijuana, including medical marijuana;

r. Prescription Drugs filled before the Member's Effective Date or after a Member's coverage ends;

s. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;

t. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (for example, Viagra®, Cialis®, Levitra®), low sexual desire disorder (Addyi®) or other sexual inadequacies;

u. 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;

v. growth hormone therapy, except for treating 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;

w. Prescription Drugs for and treatment of idiopathic short stature;

x. 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 requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy;

y. topically applied prescription drug preparations that are approved by the FDA as medical devices;

z. Prescription Drugs subject to the Step Therapy program when the Step Therapy program was not used or the drug was not approved by Us or Our Pharmacy Benefit Manager;

aa. 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;

bb. covered antihemophilic drugs, immune globulins, drugs recommend 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 the Company are covered under the medical Benefit and excluded under the pharmacy Benefit; and

cc. 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.

12. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for personal comfort, personal hygiene and convenience items including air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to a Member's home or vehicle;

13. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for palliative or cosmetic care or treatment of the foot; supportive devices of the foot; and treatment of flat feet except for Medically Necessary Surgery;

14. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for routine foot care. Benefits for a total of six (6) services, treatments, or procedures for cutting or removal of corns and calluses, nail trimming, or debriding are covered. Benefits are limited to a total of six (6) services, treatments, or procedures per Benefit Period whether such services, treatments, or procedures are provided by Network or Non-Network Providers. All other services, treatments, or procedures in excess of this limit are not covered;

15. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for any abortions other than to save the life of the mother;

16. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for diagnosing and treating Infertility including 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 CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for services, supplies or treatment related to artificial means of Pregnancy including 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 CLAIMS 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 CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a 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 CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-Covered Services.

21. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for Cosmetic Surgery, piercings, procedures, services, supplies or treatment for cosmetic purposes, unless required for a Congenital Anomaly or Mastectomy. Complications resulting from any of these items or any other non-covered items are excluded;

22. **REGARDLESS OF CLAIMS 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 and Pediatric Dental Care Benefits. This exclusion does not apply to Cleft Lip and Cleft Palate Services;

23. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for diagnosis, treatment, or surgery of dentofacial anomalies including malocclusion, temporomandibular/craniomandibular joint disorders, hyperplasia or hypoplasia of the mandible or maxilla, and any orthognathic condition. This exclusion does not apply to Cleft Lip and Cleft Palate Services;

24. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for medical exams and 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;

25. **REGARDLESS OF CLAIMS 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 the Member's condition, except as specifically provided in this Contract, or as approved by Us.

26. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY, Repatriation** of remains from an international location back to the United States is not covered. Private or commercial air and 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 CLAIMS 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 other learning disabilities. This includes Applied Behavior Analysis services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and

education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law;

28. Benefits are excluded for Applied Behavior Analysis that We have determined is not Medically Necessary. The following is also excluded: Applied Behavior Analysis rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

29. **REGARDLESS OF CLAIMS 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, for example, Outpatient department of a Hospital or Physician office;

30. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for Custodial Care, nursing home care, assisted living facility care or custodial home care, regardless of the level of care required or provided. This exclusion for Custodial Care does not apply to Habilitative Care services that the law requires Us to cover. This exclusion for Custodial Care applies to Claims for Private Duty Nursing Services that are determined by Us to be Custodial Care.

31. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for hospital charges for a well newborn, except as specifically provided in this Contract;

32. **REGARDLESS OF CLAIMS 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;

33. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for medical and surgical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP);

34. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for reversal of a voluntary sterilization procedure;

35. **REGARDLESS OF CLAIMS 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;

36. **REGARDLESS OF CLAIMS 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;

37. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for the prophylactic storage of cord blood.

ARTICLE XX. GENERAL PROVISIONS

A. This Contract

1. This Contract, the *Application for Individual Health Coverage* expressing the entire money and other consideration for coverage, the *Schedule of Benefits*, and any amendments or endorsements make up the entire Contract between the parties.

2. This Contract is guaranteed renewable at the Subscriber's option, subject to eligibility determinations and redeterminations by Us or Exchange. By paying Your premiums when they are due, You show that You want to continue coverage. We will renew or continue coverage under this Contract on a month-to-month basis, at Your option.

3. We reserve 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 Us under this Contract may be performed by Us or any of Our 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 given 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. When We end a contractual agreement with a Provider, if You have begun a course of treatment with that Provider, We will notify You that We have removed the Provider from the Blue Connect Network. If You are a continuing care patient, You can continue receiving Covered Services until the earlier of the completion of the course of treatment or 90 days after We notify You that the Provider has left the Blue Connect Network.

   b. A continuing care patient is one who is:

      (1) Undergoing a course of treatment for a Serious and Complex Condition;

      (2) Undergoing a course of institutional or Inpatient care;

      (3) Scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care;

      (4) Pregnant and undergoing a course of treatment for the pregnancy; or

      (5) Terminally ill, which means the medical prognosis is a life expectancy of 6 months or less, and receiving treatment for the terminal illness from the Provider.

   c. The provisions of continuity of care do not apply if any 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 reason for termination of a Provider's contractual agreement is as a result of fraud.

      (3) You voluntarily choose to change Providers.

      (4) You move outside of the geographic Service Area of the Provider or the HMOLA Provider Network.

      (5) Your condition does not meet the requirements to be deemed a Serious and Complex 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.

1. Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date You become aware of the alleged discriminatory action.

2. 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.

3. The Section 1557 Coordinator will investigate the complaint. This investigation may be informal. 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.

4. The Section 1557 Coordinator will issue a written decision on the grievance no later than 30 days after it is received.

5. 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. Contract Changes

Subject to all laws that apply, 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 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.

D. We Are Not Responsible 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, 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.

E. Identification Cards

We will issue an identification (ID) card to You. You must present Your ID card whenever You receive Covered Services. ID cards are not transferable. Unauthorized use of the ID card by anyone can result in termination of Your coverage. The ID card serves only to identify Members 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 premiums have actually been paid. You must carry the ID card at all times to ensure prompt receipt of Covered Services. If a card is lost or stolen, notify Us immediately.

F. Due Date for Premium Payments

1. Premiums are due and payable from the Subscriber in advance, before the coverage being rendered. Premiums are due and payable beginning on the Effective Date of the first Contract Year of this Contract and on the same date each month thereafter. This is the premium due date. This Contract 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. We 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. We will accept advance payment of premium tax credits from the federal government.

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. Contract holder 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, We may at Our sole discretion refuse to reinstate coverage.

G. Change in Premium Amount

1. This Contract will expire December 31, 2023. This Contract is renewable at Your option for the Contract Year beginning January 1, 2024. Any renewal of this Contract for the Contract Year that begins on January 1, 2024 will be subject to premium changes based on the rates that apply.

2. Except as provided in the following paragraph, We will give You 45 days' written notice of a premium change, at Your last address shown in Our records. Any change in premium will become effective on the date specified in the notice. If You continue to pay Your premium, You show that You accept the change.

3. Premiums are guaranteed for the Contract Year. However, We reserve the right to change premiums more often 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 the addition of a newly covered person. Additionally, We reserve the right to change the premium if You request a change in Contract Benefits from that which was in force at the time of the last rate determination.

4. If Your age was misstated, any amount payable or any indemnity accruing under this Contract will be such as the premium paid would have purchased at the correct age. A clerical error will not void insurance which should be in force nor will it continue insurance which should have ended.

5. If non-tobacco premiums are charged when tobacco premiums should have been charged, We may retroactively adjust the premium and collect the appropriate premium.

H. Our Right to Offer Premium Incentives

We may, at Our discretion, offer rebates, refunds, reductions of premium, or other items of value, in amounts or types determined by Us, for business purposes and healthcare quality and improvement purposes, including but not limited to the following purposes:

1. Encouraging Members to participate in quality programs;

2. Ensuring Members are better able to afford benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members who have changed insurers;

5. Rewarding Members for choosing lower cost, quality healthcare providers;

6. Rewarding Members for selecting lower cost, quality healthcare goods and products;

7. Rewarding Members for utilizing digital and other paperless forms of communication of information, including but not limited to Contract documents and materials; and

8. Reducing enrollment, technology, or administration costs of Members, when such costs are related to effectuating and/or maintaining coverage.

I. Subscriber's Right to Cancel this Contract

1. As the Subscriber, You may cancel this Contract by writing to Us or the Exchange, as applicable, at least 14 days before the date of cancellation.

2. If You write to Us, send Your notice to Us at the home office:

Individual Membership and Billing
HMO Louisiana, Inc.
Attention: Individual Membership and Billing
P. O. Box 98024
Baton Rouge, LA 70898-9024

3. **You may not verbally cancel this Contract. Return this Contract with Your written notice of cancellation.** If You do not include Your Contract when You write to Us to cancel, We will deem Your cancellation notice to include Your declaration that You made a good faith attempt to find Your Contract and the Contract is not being returned because it was lost or destroyed.

4. If You give Us a cancellation notice, the Contract will be canceled effective on the date that is 14 days from the date of Your cancellation notice or any later date You request in a written notice to Us, or on a date required by law. If Your cancellation request is given to the Exchange, the Exchange will determine the effective date of cancellation.

J. Our 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. Subscribers that are receiving advance payments of the premium tax credit by the federal government, and have made at least 1 full first month premium payment during the Benefit Period, will have a three (3) month grace period (delinquency period) to pay their share of the premiums due under this Contract. Claims will be paid during the first month of the grace period. If We do not receive the full premium due during the grace period, We will mail a delinquency or lapse notice to the Subscriber's address of record. If by the second month of the grace period We have not received all the premium payments that are due from Subscriber, Prescription Drug Benefits may immediately be denied.

   All other Claims for Covered Services received during that period will be pended, and Providers will be notified that if the Subscriber's share of the premiums due are not paid in full by the end of the grace period, Claims will be denied. If We have not been paid in full for all the premiums owed by the end of the third month of the grace period, this Contract will be cancelled effective on the last day of the first month of the grace period, and any advance payments of the premium tax credits received for months two and three of the grace period will be returned to the federal government. We will be under no obligation to guarantee later coverage to the Subscriber or his Dependents. If the Subscriber pays premium in full, he may submit a paper Prescription Drug Claim form and the Claim will be processed. Medical Claims will be automatically processed if payment in full is made.

3. Subscribers that are not receiving advance payments of the premium tax credit have 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 according to the provisions of the Contract. If We do not receive the premium due during the grace period, We will mail a delinquency or 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 Contract without further notice to the Subscriber if We do not receive Subscriber's premium at Our home office within 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. We will not be liable to pay Benefits for services rendered after the last date through which premiums have been paid. We will be under no obligation to guarantee later coverage to the Subscriber or his Dependents during the Contract Year.

4. The Subscriber agrees to pay reasonable costs and fees to Us, including reasonable attorney's fees, for Our attempt to collect any amounts owed under this Contract, including, but not limited to, unpaid premium.

K. The Subscriber agrees to pay reasonable costs and fees to Us, including reasonable attorney's fees, for Our attempt to collect any amounts owed under this Contract, including, but not limited to, unpaid premium. Our Right to Rescind Coverage, Terminate or Non-Renew the Contract for Reasons Other Than Nonpayment of Premium

1. Causes for Rescission (retroactive termination) of this Contract:

   The Subscriber or a Member commits fraud or intentionally misrepresents material fact under the terms of this Contract. The issuance of this Contract depends on the representations and statements on the *Application for Individual Health Coverage*. All representations made on it are material to the issuance of this Contract. Any information intentionally omitted from the application about any proposed Subscriber or Member will be

an intentional misrepresentation of material fact. If You enroll someone who is not eligible for coverage, We will consider it to be an act of fraud or intentional misrepresentation of material fact. In such event, We will give You 30 days' advance written notice by certified mail and will include the reason for Rescission. Rescission could be retroactive to the Effective Date of coverage.

2. Causes for termination of coverage or non-renewal of this Contract:

   a. The Subscriber fails to comply with a material Contract provision or obligation under this Contract. In such event, We will give the Subscriber 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.

   b. A Member no longer lives or resides in the Service Area where We are authorized to do business. In such event, We will give the Subscriber 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.

   c. We cease to offer this product or coverage in the market. In such event, We will give the Subscriber written notice by regular mail 90 days before the termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

   d. A Member enrolls in another Exchange Qualified Health Plan during an Open Enrollment Period or Special Enrollment Period. In such event, coverage will be terminated effective on the day before coverage in the other Qualified Health Plan begins.

      A Member is determined ineligible for this Contract at any point in time by the Exchange. In such event, coverage will be terminated effective on the last day of the month after the month in which the Exchange notifies Us of such determination, unless the Member requests an earlier termination date according to prior Contract provisions about cancellation.

L. 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 for Covered Services rendered after the date of termination of 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. You have an obligation to notify Us, within 15 days, when Dependents die or need to be taken off this Contract for any reason. We will re-calculate premiums so You pay the proper amount. No refunds will be made to You if You fail to give timely notice when a Dependent cease 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. You have an obligation to notify Us, within 15 days, after a final 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 to retain coverage until the Dependent ceases to be eligible.

5. When the Subscriber dies, all coverage on this Contract ends for all people covered by 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 or the Exchange, as appropriate, of the desire to continue coverage. Notification must be received by an HMO Louisiana, Inc.

office within 30 days after the date of termination or by the Exchange in the timeframe established by the Exchange, to establish new coverage on a new Contract.

7. If You move outside Our Service Area with the intent to move 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 and charge appropriate premium on this Contract to reflect the membership on the Contract.

M. 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 number is on the ID card.

N. 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 the Benefit Period.

O. 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.

P. Assignment

1. Your rights and Benefits payable under this Contract are Yours; You may not assign them in whole or in part to someone else. 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 in the written description of health coverage will 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 Blue Connect Network Providers, HMOLA Network Providers, and Providers in the Blue Cross and Blue Shield of Louisiana Participating Provider Network directly instead of paying You.

Q. Member and Provider Relationship

1. The choice of a Provider is Yours only.

2. We and all Blue Connect 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 about the ability of the Provider.

R. Applicable Law and Conforming Contract

This Contract will be governed and construed according to 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. This Contract will conform to the Essential Health Benefits package and requirements. If any provision of this Contract conflicts with any law of the State of Louisiana or the United States of America that applies, the Contract will be automatically amended to meet the minimum requirements of the law. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

S. 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.

T. 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 You who are its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover will be subordinate to Your right to be "made whole." We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually incurred by You 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 will 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 be required to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interests under this Contract. We and 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 Our right of subrogation and reimbursement.

4. You are required to notify Us of any Accidental Injury.

U. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that is more than the maximum Benefits available for such services under this Contract or is more than the Allowable Charge, 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 it applies, the Provider. As an alternative, 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.

V. 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.

W. Liability of Plan Affiliates

You expressly acknowledge Your understanding that the agreement is a Contract only 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 also acknowledge and agree that You have not entered into this Contract based on representations by anyone other than HMO Louisiana, Inc. and that no person, entity, or organization other than HMO Louisiana, Inc. will be held accountable or liable to You for any of HMO Louisiana, Inc.'s obligations to You created under this Contract. This paragraph does not create any additional obligations on the part of HMO Louisiana, Inc. other than those obligations created under other provisions of this Contract.

X. 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 Covered Services outside Our service area and the Claim is processed through the BlueCard® Program, the amount You pay for Covered Services is calculated based on one of the following, as determined by Us:

a. the billed charges for Your Covered Services;

b. the negotiated price that the Host Blue makes available to Us; or

c. an amount determined by applicable law.

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, twenty-four (24) hours a day, seven (7) 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 Amount 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, twenty-four (24) hours a day, seven (7) days a week.

Y. HIPAA 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.

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

We will provide to certain Medicare-eligible 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 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 You provided to Us.

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

1. before the Medicare Part D Annual Coordinated Election Period;

2. before an individual's Initial Enrollment Period (IEP) for Medicare Part D (age in);

3. prior to the Effective Date of enrollment in the Prescription Drug Coverage under this Contract;

4. whenever Prescription Drug coverage under this Contract ends or changes so that it is no longer creditable or becomes creditable; and

5. upon a Medicare beneficiary's request.

ARTICLE XXI. COORDINATION OF BENEFITS

A. Applicability

1. This section applies when a Member has healthcare coverage under more than one Plan. Plan is defined below.

2. 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 terms of coverage without concern of 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 one hundred percent (100%) of the total Allowable Expense.

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

1. Allowable Expense – Healthcare services or expenses, including deductibles, coinsurance or copayments, that are covered in full or in part by any Plan covering a Member. The following are examples of services or expenses that are and are not Allowable Expenses:

   a. A healthcare service or expense or a portion of a service or expense that is not covered by any of the Plans covering a Member is not an Allowable Expense.

   b. 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.

   c. 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.

   d. 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.

   e. 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.

   f. 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 will be the Allowable Expense for all Plans.

g. 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, prior Authorization of admissions, and preferred provider arrangements.

2. Closed Panel Plan – A Plan that provides healthcare 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 – A provision establishing an order in which Plans pay their claims and permitting Secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. The COB provision applies to the part of the Contract providing healthcare Benefits which may be reduced because of the benefits of other Plans. Any other part of the Contract providing healthcare Benefits is separate from this Contract. This 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 covered child by a court decree; or

   b. in the absence of a court decree, the parent with whom the covered child resides more than one half of the calendar year without regard to any temporary visitation.

5. Order of Benefit Determination Rules – Rules that determine whether this Contract is a Primary Plan or Secondary Plan when a Member has healthcare coverage under more than one Plan. When this Contract is Primary, We determine payment for Benefits first before those of any other Plan and without considering any other Plan's benefits. When this Contract is Secondary, We determine Benefits after those of another Plan and may reduce the Benefits We pay so that all Plan benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

6. Plan – Any of the following that provide benefits or services for medical or dental care or treatment. If separate Plans are used to provide coordinated coverage for Members of a group, the separate Plans or contracts are considered parts of the same Plan and there is no COB among those separate Plans or contracts.

   a. Plan includes:

      (1) group and non-group insurance contracts;

      (2) health maintenance organization (HMO) contracts;

      (3) group or group-type coverage through Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured);

      (4) the medical care components of long-term care Contracts, such as skilled nursing care;

      (5) the medical benefits in group or individual automobile no fault and traditional automobile or fault contracts; and

      (6) Medicare or any 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 La. R.S. 22: 1000(A)(3)(C);

(6) benefits for non-medical components of long-term care contracts;

(7) Medicare supplement policies;

(8) Medicaid plans; or

(9) coverage under other government Plans, unless permitted by law.

Each contract for coverage under 6(a) or (b), 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.

7. Primary Plan – A Plan whose benefits for a covered person's healthcare coverage must be determined without taking the existence of any other Plan into consideration.
8. Secondary Plan – A Plan that is not a Primary Plan and determines its benefits after the Primary Plan pays benefits.

C. Coordination of Benefits and Order of Benefit Determination

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 concern of the benefits under any other Plan.

   b. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan will pay or provide benefits as if it were the Primary Plan when a covered person uses a non-panel provider, except for Emergency services or authorized referrals that are paid or provided by the Closed Panel Plan.

   c. When multiple contracts providing coordinated coverage are treated as a single Plan under the Louisiana Department of Insurance (LDI) Regulation 32, then this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the Plan, the issuer designated as Primary within the Plan will be responsible for the Plan's compliance with LDI Regulation 32.

   d. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination Rules of LDI Regulation 32 decide the order in which Secondary Plans benefits are determined in relation to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan, which, under LDI Regulation 32, has benefits determined before those of that Secondary Plan.

   e. Except as provided in (f) below, a Plan that does not contain a Coordination of Benefits provision that is consistent with LDI Regulation 32 is always Primary unless the provisions of both Plans state that the complying Plan is Primary.

   f. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. 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.

2. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is Secondary Plan.

3. Order of Benefit Determination

Each Plan determines its order of benefits using the first of the following provisions that apply:

a. Non-Dependent or Dependent Provision

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 ependent 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. The Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

b. Dependent Child Covered Under More Than One Plan Provision

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 provision 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 (3)(b)(1), above, will 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 (3)(b)(1) above will 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 (3)(b)(1) or (3)(b)(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 of Coverage Provision, below, 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 will be determined by applying the birthday provision above in subparagraph (3)(b)(1) to the dependent child's parent(s) and the dependent's spouse.

c. Active Employee or Retired or Laid-off Employee Provision

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 provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

d. COBRA or State Continuation Coverage Provision

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 provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

e. Longer or Shorter Length of Coverage Provision

The Plan that covered the person as an employee, member, policyholder, subscriber or retiree for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

f. Fall-Back Provision

If none of the preceding provisions determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, this Contract will never pay more than We would have paid had We been the Primary Plan.

D. Effects on the Benefits of this Contract

1. When this Contract is Secondary, We may reduce Benefits so that the total Benefits paid or provided by all Plans during a plan year are not more than one hundred percent (100%) of the total Allowable Expenses. In determining the amount to be paid for any Claim, as the Secondary Plan, We will calculate the Benefits We would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under Our Contract that is unpaid by the Primary Plan. As the Secondary Plan, We may then reduce Our 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, as the Secondary Plan, We will credit to the Contract Deductible Amount any amounts We would have credited to the Deductible in the absence of other healthcare coverage. In any event, this Contract will never pay more than We would have paid had We been the Primary Plan.

2. The difference between the Benefit payments that We would have paid had We been the Primary Plan, and the Benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or a covered family member and used by Us to pay any Allowable Expenses not otherwise paid during the plan year. As each Claim is submitted, We will:

a. determine Our obligation to pay or provide Benefits under the Contract;

b. determine whether a benefit reserve has been recorded for You or Your covered family member; and

c. determine whether there are any unpaid Allowable Expenses during the plan year.

3. If there is a benefit reserve, as the Secondary Plan, We will use Your or Your covered family member's benefit reserve to pay up to one hundred percent (100%) of total Allowable Expenses incurred during the plan year. At the end of the plan year, the benefit reserve returns to zero. A new benefit reserve must be created for each new plan year.

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 will not apply between that Plan and other Closed Panel Plans.

You may request a copy in either paper form or electronic form of LDI Regulation 32 - 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.ldi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32-appendixc.pdf?sfvrsn=24e14b52_0**.

E. Summary

This is a summary of only a few of the provisions of Your Contract 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 healthcare 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 healthcare 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 healthcare expenses. Coordination of Benefits 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 Contract 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 healthcare expenses, unless You are covered by Medicare and both You and Your Spouse are retired;

b. The Claim is for Your Spouse's healthcare expenses, who is covered by Medicare, and You are not both retired;

c. The Claim is for the healthcare expenses of Your Dependent child who is covered by this Contract 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 provision;

(2) You are separated or divorced and You have informed Us of a court decree that makes You responsible for Your Dependent child's healthcare expenses; or

(3) There is no court decree, but You have custody of Your Dependent 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 healthcare 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 Alowable Expense is a healthcare service or expense covered by one of the Plans, including Copayments, Coinsurance and Deductible Amounts.

      (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 provider contract calls for. Health maintenance organizations and preferred provider organizations 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 healthcare 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 the plan has reduced its benefit because You did not obtain prior authorization, 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 Contract 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 plan year. At the end of the plan year any balance is erased. A new benefit reserve begins for each covered person the next year as soon as there are savings on 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 for the purpose of determining COB. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Contract 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 Contract. We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Contract. 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 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 We should have paid under this COB section, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;

2. insurance companies; or

3. other organizations.

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

ARTICLE XXII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

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

A Member may be dissatisfied about decisions We make regarding Covered Services. We consider a written Appeal as the Member's request to change an Adverse Benefit Determination made by the Company.

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 expedited Appeals processes for situations where the time frame of the standard medical Appeals 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 customer service to register a Complaint. We will attempt to resolve a Member's Complaint at the time of their call.

   Medical Benefits: call Us at 1-800-599-2583 or 1-225-291-5370

   Pediatric Dental Care Benefits: call UCD at 1-866-445-5338

   Pediatric Vision Care Benefits: call Davis Vision at 1-888-343-3470

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 their Complaint was adequately resolved or they wish to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, the Member may call Our customer service department.

   Send written Grievances to the applicable address listed below:

   <u>Medical Benefits</u>

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

Pediatric Dental Care Benefits

HMO Louisiana, Inc.
c/o United Concordia Dental
P. O. Box 69420
Harrisburg, PA 17106-9420

Pediatric Vision Care Benefits

HMO Louisiana, Inc.
c/o Davis Vision
P. O. Box 791
Latham, NY 12110

A response will be mailed to the Member within thirty (30) business days of receipt of the Member's written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is a request by telephone, made by an authorized Provider on the Member's behalf, to speak to Our medical director or a peer reviewer 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 determination. We will conduct an Informal Reconsideration within one (1) working day of Our receipt of the request.

B. Standard Appeal Process

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination for administrative Appeals and internal medical Appeals. Requests submitted to Us after one hundred eighty (180) days of Our initial Adverse Benefit Determination will not be considered.

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

If the Member has questions or needs assistance, the Member may call Our customer service department.

The Member has the right to appoint an authorized representative to speak on their behalf 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 an Adverse Benefit Determination. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing.

We will determine if a Member's Appeal is an administrative Appeal or a medical Appeal.

The Member is encouraged to provide Us with all available information to help Us completely evaluate the Appeal such as written comments, documents, records, and other information relating to the Adverse Benefit Determination.

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 the Adverse Benefit Determination.

1. Administrative Appeals

Administrative Appeals involve contractual issues and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or investigational.

Administrative Appeals should be submitted in writing to:

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

Persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the administrative Appeal. If the administrative Appeal is overturned, We will reprocess the Member's Claim, if any. If the administrative Appeal is upheld, this decision will be considered final and binding.

The administrative Appeal decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

Administrative Appeals have only one internal level of review and are not eligible for the External Appeal process with the exception of a Rescission.

2. Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational and any related prospective or retrospective review determination.

We offer the Member two (2) standard levels of medical Appeals, including an internal review of the initial Adverse Benefit Determination, then an external review.

Medical Appeals should be submitted in writing to:

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

a. Internal Medical Appeals

A Physician or other healthcare professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, We will reprocess the Member's Claim, if any. If the internal medical Appeal is upheld, We will inform the Member of their right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

The internal medical Appeal decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

b. External Medical Appeal and Rescission

For medical Appeals and Rescission, the second level will be handled by an external Independent Review Organization (IRO) that is not affiliated with Us and randomly assigned by the Louisiana Department of Insurance.

A Member must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If the Member disagrees with the internal medical Appeal decision or Rescission, a written request for an External Appeal must be submitted within four (4) months of receipt of the internal medical Appeal decision or Rescission 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 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. Appeals 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 external review will be completed within forty-five (45) days of Our receipt of the External Appeal. The IRO will notify the Member, his authorized representative, or a Provider authorized to act on the Member's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Member and Us 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.

C. Expedited Appeals

The Expedited Appeal process is available for review of an Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the 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 medical Appeal decision. An expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit 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 Benefit Determination would be significantly less effective if not promptly initiated.

Expedited Appeals are not provided for review of services previously rendered.

An Expedited Appeal is available to, and may be initiated by the Member, the Member's authorized representative, or a Provider authorized to act on the Member's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

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

1. Expedited Internal Medical Appeals

   In these cases, We will make a decision no later than seventy-two (72) hours of Our receipt of an Expedited internal medical Appeal request that meets the criteria for an Expedited Appeal. In any case where the Expedited internal medical Appeal process does not resolve a difference of opinion between Us and the Member or the Provider acting on behalf of the Member, the Appeal may be elevated to an Expedited External Appeal. 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.

2. Expedited External Medical Appeal

   An Expedited External medical Appeal is a request for immediate review, by an Independent Review Organization. The request may be simultaneously filed with a request for an Expedited internal medical Appeal, since the IRO assigned to conduct the Expedited External medical review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External medical Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

For all medical Appeals, the Office of Consumer Advocacy at the Department of Insurance is available to assist with the appeals process. You may contact the Commissioner of Insurance directly for assistance at:

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

D. No Surprises Act (NSA) Internal Appeals and External Appeals

The NSA added certain Member rights and protections that may result in a Member being eligible for internal Appeals and External Appeals. If a Member is dissatisfied about decisions We make regarding the Member's rights and protections added by the NSA, the Member may file an Appeal. Examples of the NSA Member rights and protections include the following:

1. Member cost-sharing and surprise billing protections for Emergency Medical Services;

2. Member cost-sharing and surprise billing protections related to care provided by Non-Network Providers at Network facilities;

3. Whether Members are in a condition to receive notice and provide Informed Consent to waive the NSA protections; and

4. Whether a Claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to Member cost-sharing and surprise billing; and

5. Continuity of care.

The Member is encouraged to, and should, provide Us with all available information to help Us completely evaluate the NSA Appeal such as written comments, documents, records, and other information.

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 the determination that is the subject of the NSA appeal.

The Member has the right to appoint an authorized representative for NSA Appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an Internal Appeal or External Appeal. The authorized representative may be the Member's treating Provider if the Member appoints the Provider in writing.

1. NSA Internal Appeals

   If a Member believes that We have not complied with the surprise billing and cost-sharing protections of the NSA, a written request for review must be submitted within one hundred eighty (180) days of the NSA-related Adverse Benefit Determination. Requests submitted to Us after one hundred eighty (180) days of the NSA-related Adverse Benefit Determination will not be considered.

   The NSA internal Appeals request should be submitted in writing to:

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

   If a Member has questions or needs assistance, the Member may call Our customer service department at the number on the ID Card.

   We will investigate the Member's concerns. If the NSA internal Appeal is overturned, We will reprocess the Member's Claim, if applicable. If the NSA internal Appeal is upheld, We will inform the Member of the right to begin the NSA External Appeal process.

   The NSA internal Appeal decision will be mailed to the Member, the Member's authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request, unless it is mutually agreed that an extension of time is warranted.

2. NSA External Appeals

   If a Member disagrees with the NSA Internal Appeal decision, a written request for an NSA External Appeal must be submitted within four (4) months of receipt of the NSA internal Appeal decision. Requests submitted to Us after four (4) months of receipt of the NSA internal Appeal decision will not be considered.

   You are required to sign and return the form included in the NSA internal Appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.

   The NSA External Appeals request should be submitted in writing to:

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

   If the Member has questions or needs assistance, the Member may call Our customer service department at the number on the ID Card.

   A Member must exhaust all NSA internal Appeal opportunities prior to requesting an NSA External Appeal conducted by an IRO.

   We will provide the IRO all pertinent information necessary to conduct the NSA External Appeal. The external review will be completed within forty-five (45) days of Our receipt of the request for an NSA External Appeal. The IRO will notify the Member, the Member's authorized representative, or a Provider authorized to act on the Member's behalf of its decision.

   The IRO decision will be considered a final and binding decision on both the Member and Us for purposes of determining coverage under this Contract. This NSA External Appeal process shall constitute Your sole recourse in disputes concerning whether the Company complied with the surprise billing and cost-sharing protections of the NSA, except to the extent that other remedies are available under state or federal law.

The Member may contact 1-800-985-3059 or visit **www.cms.gov/nosurprises** for more information about Member rights under the NSA.

ARTICLE XXIII. MAKING CONTRACT CHANGES AND FILING CLAIMS

HMO Louisiana, Inc. is continuing to update its online access for You. You may now be able to perform many of the functions described below without contacting Our customer service department. Log on to **www.bcbsla.com** to access these services.

You can find all of the forms mentioned in this section at one of Our local service offices or from the home office of HMO Louisiana, Inc. To submit documentation to Us, send it to Our home office at:

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

or to:

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 the ID card.

A. Changing Family Members on Your Contract

Article III of Schedule of Eligibility lets You know when You may add additional family members to Your Contract. See the Schedule of Eligibility and this section as they contain important information for You.

1. If Your coverage was purchased On-Exchange: You will need to make all Contract changes directly through the Exchange.

2. If Your coverage was purchased Off-Exchange through an agent or through HMO Louisiana, Inc.: You will need to make all Contract changes through the agent or through HMO Louisiana, Inc. A Change of Status Card is the document that We must receive to enroll family members not listed on Your original application or enrollment form. The Change of Status Card is used to add newborn children, newborn adopted children, a Spouse, or other Dependents. It is extremely important that You follow the timing rules in the Schedule of Eligibility. 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. A Change of Status Card is also required to remove existing family Members listed on Your Original application or enrollment form, or shown as covered in Our records.

If You do not complete and return a required Change of Status Card to us within the timeframes explained in the Schedule of Eligibility, Your insurance coverage may not include the additional family members or family members may not be removed from coverage.

B. How to File Insurance Claims for Benefits

We 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 Us, 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.
Claims Processing
P. O. Box 98024
Baton Rouge, LA 70898-9024

Your HMO Louisiana, Inc. ID card shows the way Your name appears on Our records. If You have Dependent coverage, the names are recorded as You wrote them on Your application card. The ID card also lists Your Contract number. This number is the identification to Your membership records and should be provided to Us each time a Claim is filed.

To help in prompt handling of Your Claims, be sure that:

1. an appropriate Claim form is used;

2. the Contract number on the form is the same as the number on the ID card;

3. the patient's date of birth is listed;

4. the patient's relationship to the Subscriber is correctly stated;

5. all charges are itemized on a statement from the Provider;

6. the itemized statement from the Provider contains the Provider's name, address, and tax ID number and is attached to the Claim form;

7. the date of service (date of Admission to a Hospital or other Provider) or date of treatment is correct;

8. the Provider includes a diagnosis code and a procedure code for each service and treatment rendered (the diagnosis code pointers must be consistent with the Claim form); and

9. the Claim is completed and signed by the Member.

C. Prescription Drug Claims

Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically when You present Your ID card to a Participating Pharmacy. 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 number is on the ID card.

Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug.

D. Other Medical Claims

When You receive other medical services (clinics, Provider offices, etc.) You should ask if the Provider is an HMO Louisiana, Inc. 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.

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

Important Note: Itemized bills submitted with Claim forms must include the following:

1. full name of patient;

2. dates of service;

3. description of and procedure code for service;

4. diagnosis code;

5. charge for service; and

6. name and address of Provider of service.

E. 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 initial's RN or LPN and registry number. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary may also need to be filed with the receipts for nursing services.

F. 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 may also need to be filed with these bills.

G. Mental Health and Substance Use Disorders

For help with filing a Claim for Mental Health or substance use disorders, see Your ID card or call customer service.

H. Claims Questions

Members can view information about the processing or payment of a Claim at **www.bcbsla.com**. Members can also write Us at the below address or call Our customer service department at the telephone number shown on the ID card or visit any of Our local service offices*. If the Member calls for information about a Claim, We can help the Member better if they have the information at hand, particularly the contract number, patient's name and date of service.

Remember, the Member should ALWAYS refer to their contract number in all correspondence and recheck it against the contract number on the ID card to be sure it is correct.

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

***** Our local service offices are located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe 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	**Department of Insurance**
P.O. Drawer 44126	P.O. Box 94214
Baton Rouge, Louisiana 70804	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 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).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, 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 بگیرند.

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)