GF INDIVIDUAL

BLUE Select

INDIVIDUAL HOSPITAL, SURGICAL AND MEDICAL CONTRACT

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

40XX1278 R01/23

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 Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana Inc., are independent licensees of the Blue Cross Blue Shield Association.

40XX0941 R09/22

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 Officer

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

INDIVIDUAL BLUE SELECT ® CONTRACT
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, DEDUCTIBLE AMOUNTS, COINSURANCES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT NETWORK AND NON-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT **WWW.BCBSLA.COM** OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE BACK OF THE ID CARD.

THE MEMBER'S SHARE OF THE PAYMENT FOR HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN THE MEMBER'S HEALTH PLAN AND THE MEMBER'S PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW THE MEMBER'S PROVIDER TO BILL THE MEMBER 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 the Deductible Amount and/or Coinsurance.

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 the Deductible Amount and/or Coinsurance.

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

INDIVIDUAL BLUE SELECT®

PRESCRIPTION DRUG FORMULARY

NOTICES

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

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

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

You may also contact Us at the telephone number on 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 review process. This process allows Your prescribing healthcare Provider to ask for a drug review from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the drug review request is not approved, You may file an internal or external drug review request to Us.

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

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

INDIVIDUAL BLUE SELECT®

CONTRACT

TABLE OF CONTENTS

		Page
ARTICLE I.	**UNDERSTANDING THE BASICS OF YOUR COVERAGE**	**5**
ARTICLE II.	**DEFINITIONS**	**10**
ARTICLE III.	**SCHEDULE OF ELIGIBILITY**	**22**
ARTICLE IV.	**BENEFITS**	**25**
ARTICLE V.	**HOSPITAL BENEFITS**	**26**
ARTICLE VI.	**MEDICAL AND SURGICAL BENEFITS**	**27**
ARTICLE VII.	**PRESCRIPTION DRUG BENEFITS**	**29**
ARTICLE VIII.	**PREVENTIVE OR WELLNESS CARE**	**32**
ARTICLE IX.	**ORAL SURGERY BENEFITS**	**34**
ARTICLE X.	**ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS**	**36**
ARTICLE XI.	**NEWBORN CARE**	**37**
ARTICLE XII.	**REHABILITATIVE CARE BENEFITS**	**37**
ARTICLE XIII.	**OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT**	**39**
ARTICLE XIV.	**CARE MANAGEMENT**	**46**
ARTICLE XV.	**LIMITATIONS AND EXCLUSIONS**	**51**
ARTICLE XVI.	**GENERAL PROVISIONS**	**59**
ARTICLE XVII.	**COORDINATION OF BENEFITS**	**70**
ARTICLE XVIII.	**COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES**	**77**
ARTICLE XIX.	**OBTAINING CARE WHILE TRAVELING, MAKING CONTRACT CHANGES AND FILING CLAIMS**	**83**

ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

Blue Cross and Blue Shield of Louisiana (Company) issues this health Contract to the Subscriber shown on the Schedule of Benefits. As of the Contract Date shown in the Subscriber's Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers and their enrolled Dependents. This Contract replaces any others previously issued to the Subscriber, as of the Contract Date or the amended Contract Date. This Contract describes Your Benefits, as well as Your rights and responsibilities under the Contract. 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. Please be aware that Your Physician does not have a copy of Your Contract, and is not responsible for knowing or communicating Your Benefits to You.

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

FACTS ABOUT THIS PREFERRED PROVIDER ORGANIZATION (PPO) CONTRACT

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

Members who get care from Providers in their Network will pay the least for their care and get the most value from this contract.

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

OUR PROVIDER NETWORK

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

Our Preferred Care PPO Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with Us to participate in the Blue Cross and Blue Shield of Louisiana PPO Provider Network and render services to Our Members. We call these Providers PPO Providers, Preferred Providers or Network Providers. Oral Surgery Benefits are also available when rendered by Providers in Blue Cross and Blue Shield of Louisiana's Dental Network.

To obtain the highest level of Benefits available, the Member should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Care PPO Provider before the service is rendered. 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 Preferred Care PPO Network Provider, or to request a paper Provider directory.

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

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

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

RECEIVING CARE OUTSIDE THE PREFERRED CARE NETWORK

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

We pay a lower level of Benefits when a Member uses a Provider outside the Preferred Care PPO Network. Benefits may be based on a lower Allowable Charge. Care obtained outside Our Network means the Member has higher costs and pays a higher Deductible Amount and/or Coinsurance than if he had stayed in the Network. **These additional costs may be significant.** In addition, We only pay a portion of those charges and it is Your responsibility to pay the remainder. The amount You are required to pay, which could be significant, does not apply to the Out-of-Pocket Amount.

We recommend that You ask Non-Network Providers to explain their billed charges to You, BEFORE You receive care outside the Network. You should review the sample illustration below in the section titled Sample Illustration of Member Costs When Care Is Obtained at a Non-Participating Hospital prior to obtaining care outside the Network.

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.

No payment will be made for Organ, Tissue and Bone Marrow Transplant Benefits or evaluations unless We Authorize these services and the services are rendered by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or a transplant facility in Our Blue Cross and Blue Shield PPO Provider Network, unless otherwise approved by Us in writing. To locate an approved transplant facility, Members should contact Our customer service department at the number listed on the ID card.

HOW WE DETERMINE WHAT WE PAY FOR COVERED SERVICES

<u>When the Member uses Network Providers</u>

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

<u>When the Member uses Participating Providers</u>

Participating Providers are Providers who have signed a contract with Us or any other Blue Cross and Blue Shield plans to participate in their Provider Networks. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. This amount is the Participating Provider's Allowable Charge and is used to determine the amount We pay for Medically Necessary Covered Services.

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

Non-Participating Providers do not have a signed contract with the Company or any other 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.

Member's usually pay significant costs when using Non-Participating Providers. This is because the amount that some Providers charge for a Covered Service may be higher than the established Allowable Charge. Also, Network Providers and Participating Providers waive the difference between the actual billed charge fir 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 the Member 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 Deductible Amount and Coinsurance. 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 previously met his 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 Hospital's for the same service.

The Member receives Covered Services from:	**Network Hospital**	**Participating Hospital**	**Non-Participating Hospital**
Hospital Bill: Allowable Charge:	$12,000 $2,500	$12,000 $3,000	$12,000 $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 $2500 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**

WHEN A MEMBER PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with the Company or with its Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount We pay Our Pharmacy Benefit Manager to base the Company's payment for a Member's covered Prescription Drugs and the amount that the Member must pay for covered Prescription Drugs.

When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with the Company or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that the Company pays Our Pharmacy Benefit Manager for covered Prescription Drugs.

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

MEMBER INCENTIVES AND VALUE-ADDED SERVICES

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

HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

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

CUSTOMER SERVICE E-MAIL ADDRESS

Blue Cross and Blue Shield of Louisiana has consolidated its customer service e-mails into a single, easy-to-remember address: **help@bcbsla.com**. Customers who need to contact Us may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit **www.bcbsla.com** and click on *Need Help?* to access our Help Center which includes Our customer service contact information.

IDENTITY PROTECTION SERVICES

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

1. Credit monitoring which monitors activity that may affect credit.

2. Fraud detection which identifies potentially fraudulent use of identity or credit.

3. Fraud resolution support that assists Members in addressing issues that arise in relation to credit monitoring and fraud detection.

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

Information about Identity Protection Services can be found at **www.bcbsla.com** or by calling the customer service telephone number on the ID card.

ARTICLE II. DEFINITIONS

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

Admission – The period from entry into a Hospital or Skilled Nursing Facility or Unit for Inpatient care, until discharge. In counting days of care, the date of entry and the date of discharge are counted as one (1) day. Observation hours billed when a Hospital does not formally admit the patient is not considered an Admission.

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, and/or approved by Us to render Covered Services. For coverage purposes under this Contract, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified 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 mandated by state law for specified services, if approved by Us to render Covered Services.

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

Allowable Charge –

A. For Preferred Providers and Participating 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 the terms of this Contract.

B. For Non-Participating Providers – The lesser of:

   1. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;

   2. an amount We establish as the Allowable Charge; or

   3. the Provider's billed charge.

Alternative Benefits – Benefits for services not routinely covered under this Contract but which We may agree to provide when it is beneficial both to the Member and to Us.

Ambulance Service – Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of

Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center: (1) Anesthesia services as needed for medical operations and procedures performed; (2) Provisions for physical and emotional well-being of patients; (3) Provision for Emergency Services; (4) Organized administrative structure; and (5) Administrative, statistical and medical records.

Appeal – A 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.

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

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

Beneficiary – A person designated by a Member, or by the terms of a health insurance Contract, who is or may become entitled to a Benefit under the contract.

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.

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

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

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

Care Coordination – Organized, information-driven patient care activities, intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator Fee – A fixed amount paid by Blue Cross and Blue Shield of Louisiana to Providers periodically for Care Coordination under a Value-Based Program.

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

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

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

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

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

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

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

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

Complication(s) – A medical condition, arising from an adverse event or consequence, which requires services, treatment or therapy and which is determined by 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 by a Physician, other than the attending Physician: (1) for a condition not related to the primary diagnosis or, (2) because the medical complexity of the patient's condition requires additional medical care.

Concurrent Review – A review of Medical Necessity, appropriateness of care, or level of care conducted during a patient's 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 opinion or advice as to the evaluation or treatment of a Member which is furnished upon the request of the attending Physician. These services are not intended to include those Consultations required by Hospital rules and regulations, anesthesia Consultations, routine Consultations for clearance for Surgery, or Consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge.

Contract – This agreement, including the Application for Coverage, the Schedule of Benefits and amendments/endorsements to this agreement, if any, entitling You and Your covered Dependents to specified healthcare coverage.

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

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

Cosmetic Surgery – Any operative procedure, treatment, or service, or any portion of an operative procedure, treatment, or service performed primarily to improve physical appearance. An operative procedure, treatment, or service 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 – A service or supply specified in this Contract for which Benefits are available when rendered by a Provider.

Creditable Coverage for HIPAA Portability – Prior coverage under any individual or Group health plan including, but not limited to, Medicare, Medicaid, government plans, church plans, COBRA and military plans. Creditable Coverage does not include specific disease policies (i.e., cancer policies), supplemental coverage (i.e., Medicare Supplement) or limited scope Benefits (i.e., accident only, disability insurance, liability insurance, Workers' Compensation, automobile medical payment insurance, credit only insurance, and/or coverage for on-site medical clinics or coverage as specified in federal regulation under which Benefits for medical care are secondary or incidental to the insurance Benefits.

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

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 any person may be able to perform with minimal instruction; or

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

We determine which services are Custodial Care.

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

Deductible Amounts -

A. Individual Deductible Amount –

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

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

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

C. Prescription Drug Deductible Amount – The dollar amount, if shown on the Schedule of Benefits, which each Member must pay within a Benefit Period prior to paying Prescription Drug 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, which is defined as that practice in which a person:

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

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

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

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

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

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

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

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

Eligible Person – A person entitled to apply to be a Subscriber or Dependent as specified in the Schedule of Eligibility.

Emergency – See Emergency Medical Condition.

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

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

Emergency Medical Services – 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.

<u>Expedited Appeal</u> – A request for immediate internal review of an Adverse Benefit 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.

<u>Expedited External Appeal</u> – 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 covered person or jeopardize the covered person'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.

<u>External Appeal</u> – 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.

<u>Gestational Carrier</u> – 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.

<u>Gene Therapy</u> – 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.

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

<u>Grievance</u> – A written expression of dissatisfaction with Us or with Provider services.

Habilitative Care – Healthcare services that help a patient keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, Cardiac Rehabilitation, Pulmonary Rehabilitation and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

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

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

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

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 Member's 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 one (1) year of unprotected intercourse.

Informal Reconsideration – A telephone request by a Provider for additional review of a Utilization Management determination. Informal Reconsideration is available only for initial or Concurrent Review determinations that are requested within ten (10) days of denial.

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

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

A. whether the medical treatment, procedure, drug, device or biological product can be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device or biological product is sought to be furnished; or

B. whether the medical treatment, procedure, drug, device or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

   1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);

   2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

   3. reference to federal regulations.

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

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

A. in accordance with nationally accepted standards of medical practice;

B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. not primarily for the personal comfort or convenience of the patient or Provider, and not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, 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.

<u>Member</u> – A Subscriber or an enrolled Dependent.

<u>Mental Disorder (Mental Health)</u> – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to: psychoses, neurotic disorders, personality disorders, affective disorders, and the specific severe mental illnesses defined by La. R.S. 22:1043 (formerly 22:669) (schizophrenia or schizoaffective disorder; bipolar disorder; panic disorder; obsessive-compulsive disorder; major depressive disorder; anorexia/bulimia; intermittent explosive disorder; post-traumatic stress disorder; psychosis NOS when diagnosed in a child under seventeen (17) years of age; Rett's Disorder; and Tourette's Disorder), and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic Mental Disorders, to be determined by the Company. The definition of Mental Disorder (Mental Health) shall be the basis for determining Benefits notwithstanding whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

<u>Negotiated Arrangement (Negotiated National Account Arrangement)</u> – An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard® Program.

<u>Network Benefits</u> – Benefits for care received from a Network Provider.

Network Pharmacy – A pharmacy contracted with Us or Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for covered Prescription Drugs they dispense to Members. Network Pharmacies may also be referred to as Participating Pharmacies.

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

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

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.

Non-Network Provider – A Provider who is not a member of Our Preferred Care PPO Provider Network or another Blue Cross and Blue Shield plan PPO Network. Participating Providers and Non-Participating Providers are Non-Network Providers.

Observation – Entry into a Hospital that does not result in an Inpatient Admission. Observation status may be up to thirty (30) hours and is not billed by the Hospital as an Inpatient Admission.

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

Open Enrollment – A period of time each Policy Year, specified on the Schedule of Benefits, during which a Subscriber and their eligible Dependents may enroll for Benefits under this Contract.

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

Out-of-Pocket Amount – The Out-of-Pocket Amounts shown below are separate amounts under the terms of this Contract. They do not accrue toward each other. In addition, neither Out-of-Pocket Amount can be used to satisfy the other Out-of-Pocket Amount.

A. Benefit Period Out-of-Pocket Amount - The maximum amount of unreimbursable expenses (in addition to any applicable Benefit Period Deductible Amount), that You must pay for Covered Services each Benefit Period.

B. Prescription Drug Out-of-Pocket Amount - The maximum amount of unreimbursable expenses (in addition to any applicable Prescription Drug Deductible Amount) that each Member must pay for covered Prescription Drugs in one Benefit Period. There is no family Prescription Drug Out-of-Pocket Amount.

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.

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

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

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

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

Pregnancy Care – Treatment or services related to all care prior to delivery, delivery, post-delivery care and any Complications arising from pregnancy. Medically Necessary abortions required in order to save the life of the mother, ectopic pregnancy and miscarriage are not considered Pregnancy Care. Since Pregnancy Care is not covered, Complications of pregnancy are not covered, except for Medically Necessary abortions required to save the life of the mother, ectopic pregnancies and spontaneous abortions (miscarriages). Benefits for Medically Necessary abortions required to save the life of the mother, ectopic pregnancies and spontaneous abortions (miscarriages) are available for all covered Members under the Hospital Benefit Article and the Medical and Surgical Benefits Article of this Contract the same as any other Covered Service.

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this Contract.

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

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

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

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

A. Preferred Provider – A Provider who has entered into a contract with Us or another Blue Cross and Blue Shield plan to participate in a PPO Network. We call these Providers PPO Providers, Preferred Providers, or Network Providers.

B. Participating Provider – A Provider that has a signed contract with Us or another Blue Cross and Blue Shield plan for other than a Preferred Care or PPO Network.

C. Non-Participating Provider – A Provider that does not have a signed contract with Us or another Blue Cross and Blue Shield plan.

Provider Incentive – An additional amount of compensation paid to a healthcare Provider by a payer, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group or population of covered persons.

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.

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

Rescission– Cancellation or discontinuance of coverage that has 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 year before the cancellation.

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

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

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

B. Full-time supervision by at least one Physician or Registered Nurse;

C. Twenty-four (24) hour nursing service by Registered Nurses or Licensed Practical Nurses; and

D. Utilization review plans for all patients.

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

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

A. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.

B. Coordination of care is required prior to drug therapy initiation and/or during therapy.

C. Unique patient compliance and safety monitoring requirements.

D. Unique requirements for handling, shipping and storage.

E. Restricted access or limited distribution.

Specialty drugs also include biosimilars. Biosimilars are drugs that are similar to currently marketed brand name drugs, but do not have the exact same active ingredient. Biosimilars are not considered generic drugs.

Speech/Language Pathology Therapy – The treatment used to manage speech/language, 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 – An Eligible Person who has satisfied the specifications of the Contract's Schedule of Eligibility Article and has applied for coverage, and to whom We have issued a Contract.

Surgery –

A. the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, incisional and excisional biopsies and other invasive procedures;

B. the correction of fractures and dislocations;

C. usual and related pre-operative and post-operative care; or

D. other procedures that We define and approve.

Telehealth Services – A mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from healthcare Providers approved by Us to render Telehealth Services. Telehealth Services give Providers the ability to render services when 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 – means a woman who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

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

Therapeutic/Treatment Vaccine – A vaccine intended to treat infection or disease by stimulating the immune system to protect 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 appointment. The Urgent Care Center does not provide routine follow-up care or wellness examinations and refers patients back to their regular Physician for such routine follow-up and wellness care.

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

Value-Based Program (VBP) – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

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

ARTICLE III. SCHEDULE OF ELIGIBILITY

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

A. Eligibility

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

2. Dependent: To be eligible to apply as a Dependent, an individual must meet the following criteria at the time of application. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Contract:

   a. Spouse.

   b. Children: A child under age twenty-six (26) who is one of the following:

      (1) born of the Subscriber; or

      (2) legally placed for adoption with the Subscriber; or

      (3) legally adopted by the Subscriber; or

      (4) a child for whom the Subscriber or his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his Spouse is a court appointed; or

      (5) child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or

      (6) a stepchild of the Subscriber; or

      (7) a grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or

      (8) the Subscriber’s child, or grandchild who is in the legal custody of and residing with the Subscriber, who is covered on the Contract before turning twenty-six (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.

B. Effective Date of Coverage

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

2. No person for whom coverage is sought will be covered under this Contract unless the application for coverage has been approved by Us and such approval has been evidenced by the issuance of an identification card or other written notice of approval. Payment of premiums to Us for any person for whom coverage is sought will not effectuate coverage unless and until Our identification 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. The following classes of coverage are available under this Contract:

a. Subscriber Only coverage means coverage for the Subscriber only.

b. Subscriber and Spouse coverage means coverage for the Subscriber and his Spouse.

c. Subscriber and Family coverage means coverage for the Subscriber, his Spouse, and one or more Dependent children.

d. Subscriber and Child (or Children) coverage means coverage for the Subscriber and one or more Dependent children.

4. When an application has been approved and any premiums for coverage have been paid in advance as required by this Contract, coverage will commence on the date We assign as Your Effective Date. No Claims will be paid for dates of service prior to Your Effective Date.

5. Special Enrollment Due to Acquiring New Dependents

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

   a. A person becomes a new Dependent of the Subscriber through marriage, birth, adoption, or placement for adoption.

   b. There is a one-month period of automatic coverage for Newly Born Infants (natural born or adopted), as described below. Any period of automatic coverage for Newly Born Infants (natural or adopted) runs concurrently with the special enrollment period for adding these infants to this Contract.

   c. The special enrollment period described in this subparagraph is a period of no less than one month and shall begin on the later of the date Dependent coverage is made available or the date of the marriage or birth.

   d. For Adopted Children other than Newly Born Adopted Infants, the one-month special enrollment period shall begin on:

      (1) For a legally adopted child, the date of the first court decree of adoption.

      (2) For a child legally placed for adoption following a voluntary act of surrender of the child to the custody of the Subscriber (or his legal representative) that becomes irrevocable, the date of placement into the Subscriber’s home.

      (3) For a child placed in the custody of a Subscriber, the date the court order awarding custody is legally effective.

   e. If the completed health questionnaire or Change of Status Card is not received within the special enrollment period, the request will be denied and any period of automatic coverage will end. Any later request to add coverage for such new Dependent must be made at Open Enrollment.

6. Newly Born Infants (Newborns)

   a. If a child is born to a Subscriber holding Subscriber Only coverage or Subscriber and Spouse coverage, the following will apply:

      (1) Such child will be covered automatically for one month from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his home, whichever is longer. This is the automatic coverage period. Automatic coverage for the child will be provided if You notify Us of the birth of the child. Coverage for the child will continue in effect thereafter, without evidence of

insurability, only upon Our receipt of a completed Change of Status Card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the child are paid when billed.

(2) If the completed Change of Status Card is not received within this period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the child must be made at Open Enrollment.

b. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), the Effective Date for coverage for such child will be the date of birth. You must notify Us within one hundred eighty (180) days of the birth to update Our records.

7. Newly Born Adopted Infants

a. If within one month of the birth of a child, the child is either: legally placed into the Subscriber’s home for adoption following a voluntary act of surrender to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to, a Subscriber holding Subscriber Only coverage, the following will apply:

(1) The Newly Born Infant will be covered automatically for one month. The one-month period begins to run from the date of legal placement into the Subscriber’s home or from the custody order, or if an ill newborn, from the date the child could have been legally placed into the Subscriber’s home had he not been ill, until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit, whichever is longer. Coverage for the child will continue in effect thereafter, without evidence of insurability, only upon Our receipt of a completed Change of Status card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the child are paid when billed.

(2) If the completed Change of Status Card is not received within this period, coverage for the child will terminate upon the expiration of the period of automatic coverage. Any later request to add coverage for the Newly Born Infant must be made at the next Open Enrollment.

b. If within one month of the birth of a child, the Newly Born Infant is either: legally placed into the Subscriber’s home for adoption following a voluntary act of surrender, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to, a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), the Effective Date for coverage for such adopted newborn child will be the date of placement into the Subscriber’s home or the date of the custody order. You must notify Us within one hundred eighty (180) days of the date of placement in the home or of the custody order to update Our records.

ARTICLE IV. BENEFITS

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

A. Payments and Coinsurance

1. Subject to the Deductible Amounts as shown on the Schedule of Benefits, the maximum limitations hereinafter provided and other terms and provisions of this Contract, We will provide Benefits in accordance with the Coinsurance shown on the Schedule of Benefits toward Allowable Charges incurred by You for Covered Services during a Benefit Period.

2. Under certain circumstances, if Company pays the healthcare Provider amounts that are Your responsibility, such as Deductible Amounts or Coinsurance, Company may collect such amounts directly from You. You agree that Company has the right to collect such amounts from You.

B. Deductible Amount

Different Deductible Amounts may apply to Covered Benefits provided by this Contract. Deductible Amounts do not accrue to the Out-of-Pocket Amount.

1. Benefit Period 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 as applicable on the Schedule of Benefits.

2. Family Deductible Amount:

   For Members in a class of coverage with more than one Member, this aggregate amount if shown on the Schedule of Benefits is the maximum Deductible Amount that a family must pay before this Contract starts paying Benefits. Once a family has met its Family Deductible Amount, this Contract starts paying Benefits for all Members of the family, regardless of whether each family member has met his individual Benefit Period Deductible Amount. No family member may contribute more than the Benefit Period Deductible Amount to satisfy the aggregate amount required of a family. Family Deductible Amounts may apply to other types of Deductible Amounts described in this Contract. Only Benefit Period Deductible Amounts accrue to the Family Deductible Amount.

3. 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 Prescription Drug Coinsurance. The Prescription Drug Deductible Amount does not accrue to the Benefit Period Deductible Amount or the Family Deductible Amount.

4. Deductible Amount Carryover:

   This Contract does not provide a fourth-quarter Benefit Period Deductible Amount carryover for charges incurred for Covered Services during the calendar months of October, November and December. The Benefit Period Deductible Amount must be met by each Member each Benefit Period.

   This Contract also does not provide a fourth-quarter Prescription Drug Deductible Amount carryover for charges incurred for covered Prescription Drugs during any one Benefit Period. The Prescription Drug Deductible Amount must be met by each Member each Benefit Period.

5. We will apply Your Claims to the Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from You, then when You receive Covered Services from another Provider, that Provider also collects Your Deductible Amount. This generally occurs when Your Claims have not been received and processed by Us. Our system will only show the Deductible Amount applied for Claims that have been processed. Therefore, You may need to pay toward the Deductible

Amount until Your Claims are submitted and processed, showing that the Deductible Amount has been met. If You overpay Your Deductible Amount, You are entitled to receive a refund from the Provider in which the overpayment was made.

C. Benefit Period Out-of-Pocket Amount

1. After the Member has met the Out-of-Pocket Amount, as shown on the Schedule of Benefits, We will pay one hundred percent (100%) of the Allowable Charge for Covered Services for the remainder of the Benefit Period.
2. After the Member has met the Prescription Drug Out-of-Pocket Amount, as shown on the Schedule of Benefits, We will pay one hundred percent (100%) of the Allowable Charge for eligible Prescription Drugs.
3. The following accrue to the Out-of-Pocket Amount of this Contract:
   a. Coinsurance.
4. The following do not accrue to the Benefit Period Out-of-Pocket Amount and, if applicable, Prescription Drug Out-of-Pocket Amount of this Contract:
   a. Deductible Amounts;
   b. any charges in excess of the Allowable Charge;
   c. any penalties the Member or Provider must pay; and
   d. charges for non-Covered Services.

D. Accumulator Transfers

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

ARTICLE V. HOSPITAL BENEFITS

To receive Benefits, You must obtain Authorization for certain services if shown on the Schedule of Benefits and the Care Management Article. You must pay any Deductible Amount and any 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 and/or clinic as well as the facility. 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.

B. Other Inpatient Hospital Services

1. Use of operating, recovery and treatment rooms and equipment.

2. Drugs and medicines including take-home Prescription Drugs.

3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.

4. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee.

5. Medical and surgical supplies, casts, and splints.

6. Diagnostic Services rendered by a Hospital employee.

7. Physical Therapy provided by a Hospital employee.

8. Psychological testing ordered by the attending Physician and performed by a Hospital employee.

C. Outpatient Services at Hospitals and Ambulatory Surgical Centers

Benefits will be provided for the services listed below when rendered for or in connection with:

1. Emergency Medical Services.

2. Surgery when performed in an Ambulatory Surgical Center, or as an Outpatient at a Hospital or at a Hospital.

D. Pre-Admission Testing

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

E. Authorization of Hospital Admissions

All Hospital Admissions (including Elective or non-Emergency and Emergency Admissions) must be Authorized as shown 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.

ARTICLE VI. MEDICAL AND SURGICAL BENEFITS

To receive Benefits, You must obtain Authorization for certain services if shown on the Schedule of Benefits and the Care Management Article. You must pay any applicable Deductible Amounts, and Coinsurance shown on the Schedule of Benefits.

The following services furnished to You by a Hospital or Ambulatory Surgical Center are covered as described below:

A. Surgical Services

1. Surgery

   a. The Allowable Charge for Inpatient and Outpatient Surgery, when performed in a Hospital or in an Ambulatory Surgical Center, 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's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

B. Outpatient Surgery When Performed in a Hospital or an Ambulatory Surgical Center

1. 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 Service

      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 procedures services are considered included in the proper comprehensive service code as determined by Us.

      (2) The Allowable Charge of the 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 or encounter 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 or more of the duplicative services is not reimbursable as it should be reimbursed only one time.

      (1) The Allowable Charge includes for all services performed at the same encounter. Any and all services, which are not considered Medically Necessary, will not be covered.

2. 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.

3. 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.

C. Other Medical Services

1. Inpatient medical care visits.

2. Inpatient Concurrent Care.

3. Inpatient Consultation (as defined in this Contract).

ARTICLE VII. PRESCRIPTION DRUG BENEFITS

Prescription Drugs are covered as shown below.

A. The Prescription Drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown on the Schedule of Benefits.

B. Some pharmacies have contracted with Us or with Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies. Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is 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 the Member's covered Prescription Drugs and the amount that the Member must pay for covered Prescription Drugs.

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

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

D. Prescription Drug Formulary

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

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

You may also contact Us at the telephone 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 review process. This process allows Your prescribing healthcare Provider to ask for a drug review from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the drug review request is not approved, You may file an internal or external drug review request to Us.

Prescription Drug Benefits - Two Tier

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

2. If a drug review 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.

   Tier 1: Generic Drugs

   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 and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on Our website at **www.bcbsla.com/pharmacy** or by calling the customer service telephone number on the ID Card. If the Prescription Drug requires prior Authorization, the Member's Physician must call the medical Authorization telephone 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 (e.g., refill prior to seventy-five percent (75%) day supply used).

3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by Us are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity Per Dispensing Limits/Allowances are based on the following: (a) the manufacturer's recommended dosage and duration of therapy; (b) common usage for episodic or intermittent treatment; (c) FDA-approved recommendations and/or clinical studies; or (d) as determined by Us.

4. Step Therapy – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, We may require the Member to first try one or more Prescription Drugs to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, We may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then We will cover a prescription written for Drug B. However, if Your Physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.

5. Step Therapy Overrides - Your Health Care 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. Select diabetic supplies, including, but not limited to, necessary continuous glucose monitors and associated supplies, insulin syringes and test strips are covered under the Prescription Drug Benefit.

G. When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when a Member files a paper Claim with Us or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that the Company pays Our Pharmacy Benefit Manager for covered Prescription Drugs.

H. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Member should submit Claims on Our Prescription Drug claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Member should contact Us or Our Pharmacy Benefit Manager at the telephone number indicated on the ID card.

I. 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. Any saving 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 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 the Coinsurance shown on the Schedule of Benefits. The Deductible Amount will not apply to Covered Services received for Preventive or Wellness Care. 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 a Network obstetrician, gynecologist or other Physician. Additional visits recommended by the Member's obstetrician, gynecologist or other Physician may be subject to the Deductible Amount and/or Coinsurance shown on the Schedule of Benefits, if not a preventive service.

2. One (1) 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.

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

1. Routine Wellness Physical Exam. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels. High-Tech Imaging Services such as an MRI, MRA, CT scan, PET scan, and nuclear cardiology are not covered under this Preventive or Wellness Care Benefit. These High-Tech Imaging Services are covered under standard Contract Benefits when the tests are Medically Necessary.

2. Well Baby Care - Routine examinations will be covered for infants under the age of 24 months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

C. Immunizations

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

2. Immunizations recommended by the Your Physician.

D. Colorectal Cancer Screenings

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

1. Fecal Immunochemical Test (FIT) for blood (1 per Benefit Period for ages 45 - 75)

2. One (1) Cologuard (FIT-fecal) DNA Testing (1 per Benefit Period for ages 45-75)

3. One (1) Computed Tomographic (CT) Colonography (1 every 5 years for ages 45-75)
4. One (1) Flexible Sigmoidoscopy (1 every 5 years for ages 45 -75)
5. One (1) Colonoscopy (1 every 10 years for ages 45-75)

Selected generic Physician prescribed colonoscopy preparation and supplies for colonoscopies covered under the Preventive or Wellness Care Benefit will be covered at no cost to You when obtained from a Network Pharmacy. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Member only under the following circumstances: Physician prescribes brand-name colonoscopy preparation and supplies because of Member's inability to tolerate selected generic colonoscopy preparation and supplies.

E. Other Wellness Services

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 You are over forty (40) years of age. A second visit shall be permitted if recommended by Your Physician for follow-up treatment within sixty (60) days after the visit if related to a condition diagnosed or treated during the visits.

F. Preventive or Wellness Care Services

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

WHAT A MEMBER PAYS FOR PREVENTIVE OR WELLNESS CARE BENEFITS		
WELLNESS BENEFIT	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Well Woman Exams		
OB/GYN office visits	No Cost	Coinsurance
Routine Pap Smear	No Cost	Coinsurance
Mammograms and Breast Ultrasounds	No Cost	Coinsurance
Breast MRIs	Coinsurance	Coinsurance
Physical Exams		
Routine Physical Exam (including related diagnostic tests)	No Cost	Coinsurance
Well Baby Care	No Cost	Coinsurance
Immunizations		
State-Mandated Immunizations	No Cost	Coinsurance
All Other Recommended by Physician	No Cost	Coinsurance
Seasonal Flu and H1N1 (Preferred Care Provider Office or Network Pharmacy)	No Cost	No Benefit
Colorectal Cancer Screenings		
Fecal Immunochemical Test (FIT) for blood	No Cost	Coinsurance
Flexible Sigmoidoscopy	No Cost	Coinsurance
Colonoscopy	No Cost	Coinsurance
Cologuard (FIT-fecal) DNA Testing	No Cost	Coinsurance
Computed Tomographic (CT) Colonography	No Cost	Coinsurance
Other Wellness Services		
PSA Test	No Cost	Coinsurance

G. COVID 19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by a Member's Physician for the purpose of making clinical decisions or treating a Member suspected of having COVID-19 are covered under this Contract. When a Member receives these services from a Network or Non-Network Provider, these services may be covered, up to the Network allowable, at no cost when required by applicable law. Non-Network Providers are able to balance bill Members 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, these services are subject to

Contract Benefits, including applicable Deductible Amounts and Coinsurance, 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. ORAL SURGERY BENEFITS

To receive Benefits, You must be an Inpatient at a Hospital or at an Ambulatory Surgical Center or as an Outpatient at a Hospital, and You must obtain Authorization for certain services if shown on the Schedule of Benefits and the Care Management Article. You must pay any applicable Deductible Amounts, and Coinsurance shown on the Schedule of Benefits.

Coverage is provided only for the following services or procedures; the highest level of Benefits is available when services are performed by a PPO Provider, or by a Provider in the United Concordia Dental Advantage Plus Network or in Blue Cross and Blue Shield of Louisiana's Dental Network. Access these Networks online at **www.bcbsla.com** or call the customer service telephone number on the ID card for a copy of the directory.

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

B. Extraction of impacted teeth.

C. Dental Care and Treatment including Surgery and dental appliances if required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal).

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

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

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

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

H. Anesthesia 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.

I. 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, please call Our customer service unit at the phone number on the ID card, and ask to speak to a Case Manager.

ARTICLE X. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

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

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

A. Acquisition Expenses

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

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or by a Blue Cross and Blue Shield of Louisiana (BCBSLA) Preferred Provider 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 department at the number listed on the ID card.

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

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

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

(1) Blood transfusions;

(2) Autologous parathyroid transplants;

(3) Corneal transplants;

(4) Bone and cartilage grafting;

(5) Skin grafting;

(6) Autologous islet cell transplants; and

(7) Other tissue transplant procedures which We determine 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 XI. NEWBORN CARE

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

A. Medical and surgical services rendered by a Physician, for treatment of illness, pre-maturity, post-maturity, congenital condition and circumcision of a newborn are covered. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.

B. Hospital Services, including services related to circumcision during the newborn’s post-delivery stay and treatment of illness, pre-maturity, post-maturity, and congenital condition of a newborn are covered. Charges for a well newborn are not covered, regardless of how they are billed.

ARTICLE XII. REHABILITATIVE CARE BENEFITS

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

An Inpatient Rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition, unless 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 prior to beginning the program and must begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition, 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, but not limited to a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.

2. Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.

3. Prevention, wellness and education related services for Occupational Therapy shall not require a referral.

B. Physical Therapy

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.

2. A licensed physical therapist may perform an initial evaluation or consultation of a screening nature to determine the need for Physical Therapy.

3. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:

    a. To children with a diagnosed developmental disability pursuant to the Member's plan of care.

    b. As part of a Home Health Care agency pursuant to the Member's plan of care.

    c. To a patient in a nursing home pursuant to the Member's plan of care.

    d. Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness.

    e. To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered and practicing within the scope of his license, including, but not limited to, a speech pathologist or by an audiologist.

2. The therapy must be used to improve or restore speech language deficits or swallowing function.

3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.

2. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

ARTICLE XIII. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

To receive Benefits, You must obtain Authorization for certain services if shown on the Schedule of Benefits and the Care Management Article. You must pay any applicable Deductible Amounts, and Coinsurance shown on the Schedule of Benefits. Benefits will be available whether provided Inpatient or Outpatient including in a Physician's office, unless otherwise stated in the specific Benefit description.

A. Accidental Injury Benefits

1. Subject to the other provisions of this Contract, If a Member incurs covered medical expenses for treatment or services as a direct result of a traumatic bodily injury sustained solely through accidental means, We agree to pay one hundred percent (100%) of the Allowable Charge for such medical expenses actually incurred, up to the maximum amount per Benefit Period shown on the Schedule of Benefits for this Accidental Injury Benefit. Once the maximum is exhausted, the Benefit Period Deductible Amount will apply and regular Benefits will be provided to the Member

2. No Benefits are available under this Accidental Injury Benefits provision for expenses that are not otherwise covered under this Contract.

3. No Benefits are available for treatment or services received in a Physician's office or Urgent Care Center, even if received as a direct result of traumatic bodily injury sustained solely through accidental means.

B. Ambulance Service Benefits

Benefits are limited to the following for Ambulance Services for local transportation when Medically Necessary:

1. for the Newly Born Infant, to the nearest Hospital or neonatal Special Care Unit for treatment of illnesses, injuries, congenital birth defects and Complications of premature birth which require that level of care; and

2. for the Temporarily Medically-Disabled Mother of the ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

3. No other Ambulance Services are available. No Benefits are available if transportation is provided for Your comfort or convenience, when a Hospital transports Members between parts of its own campus or between facilities owned or affiliated with the same entity.

4. If You have a covered Ambulance Service, and have paid a periodic fee to an ambulance membership organization with which We do not have a Provider Agreement, Benefits for expenses You have incurred for covered Ambulance Services will be based on any obligation You must pay that is not covered by the fee. If there is in effect a Provider Agreement between Us and the ambulance organization, Benefits will be based on the Allowable Charge.

C. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder is covered when rendered or prescribed by a Physician or Allied Health Professional. However, Benefits provided will not exceed two thousand, five hundred dollars ($2,500.00) per Benefit Period. You will be responsible for charges in excess of the Benefit Period maximum, if any. Charges in excess of the Benefit Period maximum are non-Covered Services and do not accrue to Your Out-of-Pocket Amount.

D. Bone Mass Measurement

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

1. An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;

2. An individual receiving long-term steroid therapy; or

3. An individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

4. Deductible Amount and Coinsurance are applicable.

E. BRCA1 and BRCA2 Genetic Testing

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

Deductible Amount and/or Coinsurance are applicable.

F. Breast Reconstructive Surgery Services and Breast Cancer Long-Term Survivorship Care

1. Under the Women's Health and Cancer Rights Act, if You are receiving Benefits in connection with a mastectomy and elect breast reconstruction, You will also receive Benefits for the following Covered Services:

   a. All stages of reconstruction of the breast on which the mastectomy has been performed 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 shall be delivered in a manner determined in consultation with You and Your attending Physician, if applicable, and will be subject to the Deductible Amount and/or 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 the Deductible Amount and/or Coinsurance.

G. Cancer Drug Benefits

Medically Necessary Benefits are available for Chemotherapy (for cancer treatment/prevention only). Also covered are supportive care drugs for cancer treatment, including but not limited to related blood modifiers, colony stimulating factors, anti-nausea medications, and drugs to prevent skeletal related events. Lab work necessary for the administration of covered chemotherapy treatment is covered, when performed within three (3) days of the chemotherapy administration.

H. Cleft Lip and Cleft Palate Services

The following services for the treatment and correction of Cleft Lip and Cleft Palate are covered:

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

2. Prosthetic treatment such as obturators, speech appliances and feeding appliances.

3. Orthodontic treatment and management.

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

5. Speech-language evaluation and therapy.

6. Audiological assessments and amplification devices.

7. Otolaryngology treatment and management.

8. Psychological assessment and counseling.

9. Genetic assessment and counseling for patient and parents.

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

I. Clinical Trial Participation

1. This Contract shall provide coverage for patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer. Coverage will be subject to any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

2. The following services are not covered:

   a. Non-healthcare services provided as part of the clinical trial;

   b. Costs for managing research data associated with the clinical trial;

   c. Investigational drugs or devices;

   d. Services, treatment or supplies not otherwise covered under the Contract; and/or

   e. Physician office visits.

3. Investigational treatments and associated protocol -related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:

   a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or for the prevention or early detection of cancer.

   b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.

c. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:

(1) One of the United States National Institutes of Health.

(2) A cooperative Group funded by one of the National Institutes of Health.

(3) The FDA in the form of an Investigational new drug application.

(4) The United States Department of Veterans Affairs.

(5) The United States Department of Defense.

(6) A federally funded general clinical research center.

(7) The Coalition of National Cancer Cooperative Groups.

d. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and, which has a multiple project assurance contract approved by the office of protection from research risks.

e. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

f. There must be no clearly superior, non-Investigational approach.

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

h. The patient has a signed institutional review board approved consent form.

J. 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, dietician 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 is 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 the Member has successfully completed the training program.

(2) The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

K. Hearing Benefits

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

   We will pay up to Our Allowable Charge for this Benefit. We may increase Our Allowable Charge if the manufacturer's cost to the Provider exceeds the Allowable Charge. In no event will We pay more than one

thousand, four hundred dollars ($1,400.00) per hearing aid, per ear, in a thirty-six (36) month period. If You purchase a hearing aid that costs more than one thousand, four hundred dollars ($1,400.00), You are responsible for all amounts above one thousand, four hundred dollars ($1,400.00). Charges over one thousand, four hundred dollars ($1,400.00) are non-covered charges and do not accrue to Your Out-of-Pocket Amount. This Benefit is not subject to Deductible Amounts and Coinsurance.

2. Implantable bone conduction hearing aids, cochlear implants, and bone-anchored hearing aids (BAHA) are covered for all eligible Members, regardless of age, the same as any other service or supply, subject to Medical Necessity and payment of the applicable Deductible Amount and/or Coinsurance.

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 COMPANY PRIOR TO SERVICES BEING PERFORMED; AND (2) SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM COMPANY TO PERFORM YOUR PROCEDURE.

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. 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.

O. Home Health Care Benefits

Home Health Care services provided to a Member in lieu of an Inpatient Hospital Admission are covered, and may be limited if shown on the Schedule of Benefits.

P. Hospice Care

Hospice Care is covered and may be limited if shown on the Schedule of Benefits.

Q. 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 the services are rendered by a family member, or if the medical treatment or diagnostic Consultation is not covered.

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

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

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

Benefits shall not exceed two hundred dollars ($200.00) per month, and are subject to applicable Deductible Amounts and Coinsurance as shown on the Schedule of Benefits.

You are responsible for all amounts above two hundred dollars ($200.00) per month. Charges over two hundred dollars ($200.00) per month are non-covered charges and do not accrue to Your Out-of-Pocket Amount.

S. Lymphedema

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

T. Other Benefits

Benefits are available for the following services when performed by a Provider authorized to administer such services. No Physician office visits are covered. When any of the below services are provided in an Emergency room, a Member must meet the requirements of the Hospital Benefits Article, Outpatient Services at Hospitals and Ambulatory Surgical Centers section, except for any prior Authorization requirements, in order for Benefits to be available.

1. Radiation therapy and high intensity x-ray therapy. Lab work necessary for the administration of these therapies is covered, when performed within three (3) days of the therapy.

2. Hemodialysis. Lab work necessary for the administration of covered hemodialysis is covered, when performed within three (3) days of the hemodialysis.

3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.

4. Nuclear medicine, ultrasound, MRI, PET Scans, cardiac catheterization and computerized tomography.

U. Permanent Sterilization Procedures

Benefits are available for surgical procedures and/or contraceptive devices that result in permanent sterilization, including tubaligation, vasectomy, and hysteroscopic placement of micro-inserts into the fallopian tubes. Benefits are not available if performed in a Physician’s office.

V. 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.

W. Prescription Drugs

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

X. Prosthetic Appliances and Devices and Prosthetic Services of the Limbs only

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:

1. 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).

2. 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.

3. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the device or appliance.

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

   a. 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.

   b. 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.

5. 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.

6. All Prosthetic Appliances and Devices and Prosthetic Services of the Limbs will accrue to the Benefit Period Maximum for each limb as shown on the Schedule of Benefits.

Y. Telehealth Services

Benefits are available to You for the diagnosis, consultation, treatment, education, care management, patient self-management, and caregiver support when You and your Provider are not physically located in the same place.

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 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.

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

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 no coverage for Telehealth 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 and the Providers who can render those services are determined by Us.

ARTICLE XIV. 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, the Member 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 a 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 Deductible Amount and/or 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 Deductible Amount and/or Coinsurance whether or not the Deductible Amount and/or 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 prior to the 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 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 the Deductible Amount and/or 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 the Deductible Amount and/or 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 Allowable Charges 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 the Deductible Amount and/or Coinsurance.

(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 the Deductible Amount and/or 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 the Company 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 the Member must pay all charges incurred during the Admission for which Authorization was denied.

(2) If Authorization is not requested prior to an Admission, We will have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.

(3) Additional amounts for which the Member is responsible because Authorization of an Elective or non-Emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

It is the Member's responsibility to ensure that the 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 his 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 the Member 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 the 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 the 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 in advance of incurring additional charges.

(3) Charges for non-Authorized days in the Hospital that the Member must pay are considered non-covered and will not apply toward satisfying the Out-of-Pocket Amount.

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

Certain services, supplies, and Prescription Drugs require Our Authorization before a Member receives the services, supplies, or Prescription Drugs. The Authorizations list is shown on the Member's Schedule of Benefits. The Member is responsible for making sure the Provider obtains all required Authorizations before services, supplies, or Prescription Drugs are received. 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 a 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 accrue to the Out-of-Pocket Amount.

B. Disease Management

1. Qualification

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

2. Disease Management Benefits

   Blue Cross and Blue Shield of Louisiana's Disease Management programs are committed to improving the quality of care for You as well as decreasing healthcare costs in populations with a chronic disease. The nurse works with You to help You learn the self-care techniques You will need in order to manage Your chronic disease, establish realistic goals for lifestyle modification, and improve adherence to Your Physician prescribed treatment plan. Blue Cross and Blue Shield of Louisiana is dedicated to supporting the Physician efforts in improving Your health status and well-being.

C. Case Management

1. You may qualify for Hospice Care, Home Health Care or other 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 You will not entitle any other covered person to Case Management services or be construed as a waiver of Our right to administer and enforce this Contract in accordance with its express terms.

4. Unless expressly agreed upon by the Company, all terms and conditions of this Contract, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect with respect to 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 the Member elects not to participate in the Case Management plan.

D. Alternative Benefits

1. The Member may qualify for Alternative Benefits, at the Company's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Member and to the Company.

2. The Company's determination that a particular Member's medical condition renders the Member a suitable candidate for Alternative Benefits will not obligate the Company 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 the Company's right to administer and enforce this Contract in accordance with its express terms.

3. Unless expressly agreed upon by the Company, all terms and conditions of this Contract, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Member is receiving Alternative Benefits.

4. Alternative Benefits provided under the section are provided in lieu of the Benefits to which the Member is 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 the Member is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.

    b. The Member receives care, treatment, services, or supplies for the medical condition that are excluded under this Contract, and that are not specified as Alternative Benefits approved by Us.

ARTICLE XV. LIMITATIONS AND EXCLUSIONS

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

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

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

D. 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 exceeding the Allowable Charge.

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

4. Benefits are excluded for 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 termination 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 Blue Cross and Blue Shield of Louisiana or any Blue Cross or Blue Shield Company, or to the extent provided for under any other Contract, except as allowed by law, and except for limited Benefit policies;

   e. which are Investigational in nature, except as specifically provided in this Contract. Investigational determinations are made in accordance with 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

i. by a Provider who is the Member's Spouse, child, stepchild, parent, stepparent or grandparent;

j. 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.

k. for charges for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider;

l. for services performed in the home unless the services meet the definition of Home Health Care, are 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. 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; or

   e. for treatment of any Member detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.

6. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses in connection with or related to, or Complications from the following**:**

   a. rhinoplasty;

   b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;

   c. gynecomastia;

   d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Contract;

   e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, Complications and/or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Contract;

   f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, Complications and/or treatment in relation to or as a result of penile prosthesis;

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs, except services required to be covered by law;

j. treatment related to erectile or sexual dysfunctions or other inadequacies.

k. industrial testing or self-help programs including, but not limited to stress management programs, work hardening programs and/or functional capacity evaluations, driving evaluations, etc., except services required to be covered by law;

l. recreational therapy;

m. Inpatient pain rehabilitation or pain control programs; and/or

n. primarily to enhance athletic abilities.

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

   a. routine eye exams, eyeglasses or contact lenses or exams (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered 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/or hair implants;

   e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser Surgery; or

   f. visual therapy.

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

   a. any costs of donating an organ or tissue for transplant when a Member is a donor except as provided in this Contract;

   b. transplant procedures for any human organ or tissue transplant not specifically listed as covered. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;

   c. the transplant of any non-human organ or tissue; or

   d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Contract.

   e. Gene Therapy or Cellular Immunotherapy if prior Authorization is not obtained or if the services are performed at an administering Facility that has not been approved in writing by the Company prior to services being rendered.

9. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any of the following, except as specifically provided for in this Contract:

   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.

10. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products or prescription donor human breast milk as described in this Contract.

11. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for the treatment of eating disorders, unless otherwise required by law.

12. Benefits are excluded for Prescription Drugs that We determine are not to be Medically Necessary for the treatment of illness or injury. The following are also excluded unless shown as covered on the Schedule of Benefits:

a. lifestyle-enhancing drugs including, but not limited to, medications used for cosmetic purposes (e.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 (e.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 treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical journals or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by Us;

e. fertility drugs;

f. nutritional or dietary supplements, or herbal supplements and treatments. Low Protein Food Products 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 there is an OTC-equivalent or for which a similar alternative exists as an OTC medication;

j. contraceptive drugs ;

k. all methods of contraception;

l. refills in excess of the number specified by the Physician or the dispensing limitation described in this Contract, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;

m. any drugs used for smoking cessation; (except Zyban®);

n. compounded drugs that exhibit any of the following characteristics:

   (1) are similar to a commercially available product;

   (2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval;

   (3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically);

   (4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or

   (5) compounded prescriptions whose only ingredients do not require a prescription;

o. selected Prescription Drug products that contain more than one (1) active ingredient (sometimes called combination drugs);

p. Prescription Drug products that include or are packaged with a non-Prescription Drug product;

q. Prescription Drug compounding kits;

r. selected Prescription Drug products that are packaged in a way that contains more than one (1) Prescription Drug;

s. 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);

t. Prescription Drug products that contain marijuana, including medical marijuana;

u. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;

v. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage or breakage;

w. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®);

x. 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;

y. Growth hormone therapy, except for the treatment of chronic renal insufficiency, AIDS wasting, Turner's Syndrome, Prader-Willi syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms the growth hormone deficiency with abnormal provocative stimulation testing;

z. Prescription Drugs for and/or treatment of idiopathic short stature;

aa. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis,

where a prescriber agrees prescriptions were obtained through Member misrepresentation to that prescriber. Limitation may include, but is not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy;

bb. topically applied Prescription Drug preparations that are approved by the FDA as medical devices;

cc. Prescription Drugs subject to the Step Therapy program when the Step Therapy program was not utilized or the drug was not approved Us or Our Pharmacy Benefit Manager;

dd. Therapeutic/Treatment Vaccines, except as shown as covered on the Schedule of Benefits;

ee. 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;

ff. covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include but are not limited to intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as determined by Us are covered under the medical benefit and excluded under the pharmacy Benefit; or

gg. 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.

13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to a Member's home or vehicle.

14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for routine foot care; palliative or cosmetic care or treatment and treatment of flat feet; except for Medically Necessary Surgery. Additionally, Benefits for cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot are available for persons who have been diagnosed with diabetes when those services are Medically Necessary.

15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any abortions, except abortions required in order to save the life of the mother.

16. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits.

17. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and drug or hormonal therapy administered as part of the treatment.

18. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.

19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for acupuncture, anesthesia by hypnosis or charges for anesthesia for non-Covered Services.

20. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Cosmetic Surgery, piercings, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly or Mastectomy. Complications resulting from any of these items or any other non-covered items are excluded.

21. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Contract under Oral Surgery Benefits. This exclusion does not apply to Cleft Lip and Cleft Palate coverage.

22. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for diagnosis, treatment, or Surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition. This exclusion does not apply to Cleft Lip and Cleft Palate coverage.

23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Contract.

24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for travel expenses of any kind or type other than covered Ambulance Services to the closest Hospital equipped to adequately treat your condition, except as specifically provided in this Contract, or as approved by Us.

25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY**, Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Members traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to your home country and air/sea travel when ambulance is not required.

26. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and learning disabilities. This includes Applied Behavior Analysis services. This exclusion does for educational services and supplies does not apply to training and education for diabetes.

27. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Applied Behavior Analysis.

28. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.

29. **REGARDLESS OF CLAIM 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.

30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Hospital charges for a well newborn, except as specifically provided in this Contract.

31. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for the treatment of Mental Health or substance use disorders. Behavioral health services for any and all diagnoses, except as specifically provided in this Contract.

32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling and employment counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.

33. **REGARDLESS OF CLAIM 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 CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for reversal of a voluntary sterilization procedure.

35. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for or in connection with or related to the following, except as may be required by law:

    a. Physician office or Urgent Care visits, except for those provided under the Preventive or Wellness Care and Rehabilitative Care Benefits Articles, or as specifically listed as covered in this contract.

    b. Any Durable Medical Equipment, disposable medical equipment, items and supplies, except as specifically listed as covered in this Contract. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by Us.

    c. Orthotic Devices.

    d. Prosthetic Appliances and Devices, except for as specifically provided in this Contract.

    e. Private Duty Nursing Services.

36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Hospital, medical and surgical services rendered for Pregnancy Care. Medically Necessary abortions required in order to save the life of the mother, ectopic pregnancy and miscarriages are not considered Pregnancy Care and are covered under the Hospital Benefits and Medical and Surgical Benefits Articles.

37. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for observation hours billed when a Hospital does not formally admit the patient.

38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a covered Member related to:

    a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Member or as required by law;

    b. Pre-implantation genetic diagnosis;

    c. Preconception carrier screening; and

    d. Prenatal carrier screening except screenings for cystic fibrosis.

39. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for the prophylactic storage of cord blood.

40. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for sleep studies.

ARTICLE XVI. GENERAL PROVISIONS

A. This Contract

1. This Contract, including the Application for Coverage expressing the entire money and other consideration therefore, the Schedule of Benefits, and any amendments or endorsements, constitutes the entire Contract between the parties.

2. This Contract is guaranteed renewable at the Subscriber's option. The Subscriber indicates his desire to continue coverage by his timely payment of each premium as it becomes due. We shall renew or continue coverage under this Contract on a month-to-month basis, at Your option.

3. The Company reserves the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties relative to this Contract. Any function to be performed by the Company under this Contract may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.

4. Our liability is limited to the Benefits specified in this Contract. Benefits for Covered Services specified in this Contract will be provided only for services and supplies rendered on and after Your Effective Date by a Provider specified in this Contract and regularly included in such Provider's charges.

5. Continuity of healthcare services.

   a. Upon the termination of a contractual agreement with a Provider, notification of the removal of the Provider from the Blue Cross and Blue Shield of Louisiana PPO Provider Network will be given by Us to any Member who has begun a course of treatment by the Provider.

   b. A Member has the right to continuity of care applicable to the following provisions and subject to consent of the treating Provider:

      (1) In the event the Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth (24th) week of pregnancy, the Member shall be allowed to continue receiving covered services through delivery and postpartum care related to the pregnancy and delivery.

      (2) In the event the Member has been diagnosed with a Life-Threatening Illness, the Member shall be allowed to continue receiving Covered Services until the course of treatment is completed, not to exceed three (3) months from the effective date of termination of the Provider's contractual agreement.

6. The provisions of continuity of care shall not be applicable if any one of the following occurs:

   a. 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.

   b. The Member voluntarily chooses to change Providers.

   c. The Member relocates to a location outside of the geographic service area of the Provider or the Blue Cross and Blue Shield of Louisiana PPO Provider Network.

   d. The Member's chronic condition only requires routine monitoring and is not in an acute phase of the condition.

B. Section 1557 Grievance Procedure

Blue Cross and Blue Shield of Louisiana does not discriminate on the basis of race, color, national origin, sex, age or disability. Blue Cross and Blue Shield of Louisiana 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 Blue Cross and Blue Shield of Louisiana 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 Blue Cross and Blue Shield of Louisiana to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date You become aware of the alleged discriminatory action.

- A complaint must be in writing, containing Your name and address. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

- The Section 1557 Coordinator will investigate the complaint. This investigation may be informal, but it will be thorough. You are encouraged to submit evidence related to Your complaint. The Section 1557 Coordinator will maintain the files and records of Blue Cross and Blue Shield of Louisiana relating to such grievances. To the extent possible, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance no later than 30 days after it is received.

- You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within 15 days of receiving the Section 1557 Coordinator's decision. The Section 1557 Grievance Administrator shall issue a written decision in response to the appeal no later than 30 days after it is received.

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

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

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

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

C. Non-Responsibility for Acts of Providers

We will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with Your care or treatment.

D. Identification Cards

We will issue an identification (ID) card to You. You must present Your identification card whenever Covered Services are rendered. Identification cards are not transferable. Unauthorized use of the identification card by any person can result in termination of Your coverage. The identification card serves only to identify the covered Member and confers no right to Covered Services or Benefits. To be entitled to Covered Services or Benefits an identification cardholder must be a Member on whose behalf all applicable premiums have actually been paid. A Member must carry the identification card with them at all times to assure prompt receipt of Covered Services. If a card is lost or stolen, please notify Us immediately.

E. Contract Changes

Subject to applicable laws, no agent may change this Contract other than by amendment or endorsement issued by Us to form a part of this Contract. This amendment or endorsement must be signed by one of Our executive officers or his delegate. No representation of any agent of the Contract at any time shall change the terms of this Contract. Changes will be effective upon renewal of the Contract and preceded by not less than sixty (60) day notice to You.

F. Due Date for Premium Payments

1. Premiums are due and payable from the Subscriber in advance, prior to the coverage being rendered. Premiums are due and payable beginning on the Effective Date of the first Policy Year of this Contract and on the same date each month thereafter. This is the premium due date. This contract is renewable on a monthly basis by the timely payment of each premium as it becomes due.

2. Premiums are owed by the 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. The Company will not accept premium payments by third parties unless required by law to do so. The fact that We may have previously accepted a premium from an unrelated third party does not mean that We will accept premiums from these parties in the future.

3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean We will accept a late 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 U.S. dollars. Policyholder will be assessed a twenty-five dollar ($25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, the Company may, at its sole discretion, refuse to reinstate coverage.

G. Change in Premium Amount

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

2. We reserve the right to increase the premiums for this Contract after the first Policy Year twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as

described in the following paragraph. Except as provided in the following paragraph, We will give forty-five (45) days written notice to You of a premium change, at Your last address shown in Our records. Any increase in premium will become effective on the date specified in the notice. Continued payment of premium will constitute acceptance of the change.

3. We reserve the right to increase premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Contract. This risk includes, but is not limited to, the addition of a newly covered person. Additionally, We reserve the right to increase the premium if You request a change in contract Benefits from that which was in force at the time of the last rate determination. Such increase in premium will become effective on the next billing date following the Effective Date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

H. The Subscriber's Right to Cancel This Contract

1. The Subscriber may cancel this Contract for any reason.

2. To cancel the contract, the Subscriber must give the Company WRITTEN NOTICE of his intent to cancel. Written notice should be sent to the Company at the home office, attention Individual Membership and Billing:

Blue Cross and Blue Shield of Louisiana
Attention: Individual Membership and Billing
P. O. Box 98029
Baton Rouge, LA 70898-9029

3. THE SUBSCRIBER MAY NOT VERBALLY CANCEL THIS COVERAGE. THE SUBSCRIBER'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO THE COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE CONTRACT. If the Subscriber's written notice to the Company of his intent to cancel is not accompanied by the surrendered contract, the Subscriber's cancellation notice to the Company shall be deemed to include the Subscriber's declaration that the Subscriber made a good faith attempt to locate his contract and the contract is not being returned because it has been lost or destroyed.

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

1. Premiums are to be prepaid before coverage is rendered. The Subscriber is considered delinquent if premiums are not paid on the due date.

2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the Contract. If We do not receive the premium 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 the Subscriber's premium at Our home office within thirty (30) days of the due date (during the grace period). If We terminate this Contract for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

3. 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.

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

1. The Company may choose to rescind coverage, terminate or non-renew this Contract if any one of the following occurs:

   a. The Subscriber or a covered Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Contract. The issuance of this

Contract is conditioned on the representations and statements contained on the application, a copy of which is attached to and made a part of this Contract. All representations made on the application are material to the issuance of this Contract. Any information provided on the application, or intentionally omitted therefrom, as to any proposed Subscriber or covered Member shall constitute an intentional misrepresentation of material fact. If you enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

b. The Subscriber fails to comply with a material contract provision or obligation under this Contract, including, but not limited to provisions relating to eligibility.

c. In the case of Network contracts, You no longer live, reside, or work in Our service area in or in the service area for which We are authorized to do business.

d. The Company ceases to offer this product or coverage in the market.

2. If the Company decides to rescind this coverage because of a. above, the Company will give the Subscriber thirty (30) days advance written notice by certified mail and will include the reason for rescission. Rescission would be retroactive to the Effective Date of coverage.

3. If the Company decides to terminate or not renew this coverage because of b or c, the Company will give the Subscriber sixty (60) days advance written notice by certified mail and will include the reason for termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

4. If the Company decides to terminate or not renew this coverage because of d, the Company will give the Subscriber written notice by regular mail ninety (90) days in advance of the termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

K. Termination of a Member's Coverage

1. All coverage will end at the end of the period for which premiums have been paid. No Benefits are available to You for Covered Services rendered after the date of termination of Your coverage. However, if You or Your Dependent is an Inpatient in a Hospital on the date of termination, medical Benefits in connection with the Admission for that patient will terminate at the end of that Admission or upon reaching any Benefit limitations set in this Contract, whichever occurs first.

2. 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 ceases to be eligible to keep coverage or when a Dependent's coverage should have been terminated.

3. Coverage for the 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. The Subscriber has an obligation to notify Us, within 15 days, after a final decree of divorce or other legal termination of marriage is rendered.

4. Coverage for Dependents terminates automatically, without notice, at the end of the year the Dependent ceases to be an eligible Dependent, unless it is specifically otherwise stated in this Contract or as provided by law. Premiums are required to be paid in order to retain coverage until the Dependent ceases to be eligible.

5. Upon the death of the Subscriber, all coverage on this Contract ends for all covered persons on the Contract. Termination is automatic and without notice. Termination is effective at the end of the billing period in which the Subscriber's death occurred, if premiums have been paid through that billing cycle.

6. If the Spouse or other covered Dependents wish to continue coverage, he must notify Us of his desire to continue coverage. Notification must be received by a Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. office within thirty (30) days after the date of termination.

If notification is received within thirty (30) days of the termination, the Member's coverage will continue and the Member will not be subject to evidence of insurability.

7. In the event that You move outside Our service area with the intent to relocate or establish a new residence outside Our service area, Your coverage will be terminated.

8. We reserve the right to automatically change the class of coverage on this Contract to reflect the membership on the Contract.

L. Filing of Claims

1. You must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.

2. Most Members that have Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for You. However, if You must file a Claim to access Your Prescription Drug Benefit, You must use the Prescription Drug Claim form. The Prescription Drug Claim form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose number is on the ID card.

M. Applicable Law

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

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 personal to You and may not be assigned in whole or in part by You. We will recognize assignments of Benefits to Hospitals if both this Contract and the Provider are subject to La. R.S. 40:2010. If both this Contract and the Provider are not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the health contract 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 PPO Providers and Hospitals, and Providers and Hospitals in Our Participating Provider Network directly instead of paying You.

Q. Member/Provider Relationship

1. The choice of a Provider is solely Yours.

2. We and all Network Providers are to each other independent contractors, and will not be considered agents, representatives, or employees of each other for any purpose whatsoever. Blue Cross and Blue Shield of Louisiana 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. The use or non-use of an adjective such as Preferred Network, Participating, and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

R. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Contract, We will be subrogated and will succeed to Your right for the recovery of the amount paid under this Contract against any person, organization or other carrier even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover shall be subordinate to 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 shall be subordinate to Your right to be "made whole." We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.

3. You will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interest under this Contract. We 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/or reimbursement.

4. You are required to notify Us of any Accidental Injury.

S. Right of Recovery

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

T. 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.

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.

U. Proxy Votes

Election of Our Board of Directors and certain significant corporate transactions are determined by a majority vote of Our policyholders, unless a different vote is required by law or Our Articles of Incorporation or Bylaws. A policyholder designates, by means of the application for coverage, the members of Our Board of Directors as his proxy to vote on these important matters. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder. This proxy may be revoked by the policyholder by giving written notice of the revocation. This revocation may be in any form of writing either revoking the proxy or designating a different proxy and must be sent to Us at:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, Louisiana 70898-9029

In lieu of giving his proxy in the application for coverage, the policyholder may designate any other policyholder as his proxy by any form of writing which includes the policyholder's name and policy number, sent to Us as indicated above. Notice of meetings to the proxy constitutes notice to the policyholders giving their proxies. Further, notice is hereby given that Our annual meeting is held in the month of February with notice of the date of that meeting being given as required by law and the articles and bylaws of the Louisiana Health and Service Indemnity Company. However, additional notice of meetings will be sent to any policyholder or his proxy upon his written request for such notice directed to Our secretary.

V. Extension of Time Limitations

If any limitation for:

1. giving notice of Claim; or

2. bringing any action on this Contract, is less than that allowed by the state, district or territory where You reside at the time this Contract is issued, the limitation is extended to comply with the law.

W. Liability of Plan Affiliates

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

X. Out-of-Area Services

Blue Cross and Blue Shield of Louisiana 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 the geographic area We serve, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of Our service area, 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) do not contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, 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 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.

   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 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.

2. Special Case: Value-Based Programs

   a. BlueCard® Program

      If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

   b. Negotiated (non-BlueCard® Program) Arrangements

      If We have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Our Members, We will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

   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.

4. Non-Participating Providers Outside Our Service Area

   a. Member Liability Calculation

      When Covered Services are provided outside of Our service area 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 Covered Services as set forth in this paragraph.

      Federal or state law, as applicable, may govern payments for out-of-network Emergency Medical Services.

   b. Exceptions

      In certain situations, We may use other payment methods, such as billed charges for 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 Covered Services as set forth in this paragraph.

5. 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 shall 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 deemed creditable if it is at least as good as the standard Medicare Part D Prescription Drug Benefit. We will give these certificates to Covered individuals who are eligible for Medicare Part D based on enrollment data provided to Us by the Subscriber or Member.

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

1. prior to the Medicare Part D Annual Coordinated Election Period;

2. prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D (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 it becomes creditable; and/or

5. upon a Medicare beneficiary's request.

AA. 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 and/or policyholders to participate in quality programs;

2. Ensuring Members and/or policyholders are better able to afford benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;

5. Rewarding Members and/or policyholders for choosing lower cost, quality healthcare providers;

6. Rewarding Members and/or policyholders for selecting lower cost, quality healthcare goods and products;

7. Rewarding Members and/or policyholders 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 and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

ARTICLE XVII. COORDINATION OF BENEFITS

A. Applicability

This section applies when a Member has healthcare coverage under more than one Plan is defined below.

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 deductible, 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 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 – 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 or contracts 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 Determinations

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 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 the 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 dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a dependent; and Primary to the Plan covering

the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed. 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 Amount 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 and 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 You and 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 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 Allowable 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 fresh 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 XVIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

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

A Member may be dissatisfied about decisions We make regarding Covered Services. We consider 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 medical 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 Appeal 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

2. To File a Formal Grievance

   A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel his Complaint was adequately resolved or he wishes to file a formal Grievance, 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:

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

A response will be mailed to the 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 determinations. We will conduct an Informal Reconsideration within one (1) working day of Our receipt of the request.

B. Standard Appeal Procedures

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

We offer the Member two (2) levels of Appeal. If a Member is an ERISA Member, the Member is required to complete the first level of Appeal prior to instituting any civil action under ERISA section 502(a). The second level of Appeal is voluntary. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the contract. No fees or costs will be imposed on the Member.

The Member should contact his Employer, Plan Administrator, Plan Sponsor, or Our customer service department at 1-800-599-2583 or 1-225-291-5370 if the Member is unsure whether ERISA is applicable.

The Member may also call Our customer service department if they have questions or need assistance putting their Appeal in writing.

C. Standard Appeal Process

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

The Member 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 his Adverse Benefit Determination.

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

1. Administrative Appeals

Administrative Appeals involve contractual issues, Rescissions of Coverage, 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:

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

a. First Level Administrative Appeals

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of Our initial Adverse Benefit Determination for first level administrative Appeals.

Requests submitted to Us after one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination will not be considered.

We will investigate the Member's concerns. If the administrative Appeal is overturned, We will reprocess the Member's Claim, if any. If the administrative Appeal is upheld, We will inform the Member of the right to begin the second level Appeal process.

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.

b. Second Level Administrative Appeals

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

A Member Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is final and binding.

The Committee's decision will be mailed to the Member, his authorized representative, or a Provider authorized to act on the Member's behalf, within five (5) days of the Committee meeting.

Second Level administrative Appeals are not applicable to a Rescission, which follows the External Appeals track.

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 sent to:

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

a. Internal Medical Appeals

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of Our initial Adverse Benefit Determination for internal medical Appeals.

Requests submitted to Us after one hundred eighty (180) days of Our initial Adverse Benefit Determination will not be considered.

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 Appeals and Rescissions

For medical Appeals and Rescissions, 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 still 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.

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.

D. 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:

Blue Cross and Blue Shield of Louisiana
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 of 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

E. 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.

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:

   Blue Cross and Blue Shield of Louisiana
   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:

   Blue Cross and Blue Shield of Louisiana
   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 XIX. OBTAINING CARE WHILE TRAVELING, MAKING CONTRACT CHANGES AND FILING CLAIMS

Blue Cross and Blue Shield of Louisiana is continuing to update its online access for Members. Members may now be able to perform many of the functions described below, without contacting Our customer service unit. We invite Members to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from one of Our local service offices* or from the home office of Blue Cross and Blue Shield of Louisiana. The Change of Status Card has the health questionnaire on the reverse side. This form should also be available through Your insurance agent. You may also make some contract changes on Our website at **www.bcbsla.com**.

If You need to submit documentation to Us, You may forward it to Our home office at Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809. If You have any questions about any of the information in this section, You may call Your insurance agent or Our customer service department at the telephone number shown on the ID card.

A. How To Obtain Care While Traveling

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

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

B. Changing Family Members On Your Contract

The Schedule of Eligibility in Your Contract or certificate of coverage lets You know how to add additional family members to Your contract. Please read the Schedule of Eligibility and this section as they contain important information for You.

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

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

C. How To File Insurance Claims For Benefits

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

The ID card shows the way the name of the Subscriber appears on the Company records. If You have Dependent coverage, the names are recorded as You wrote them on Your application. 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 assist in promptly handling Your Claims, please be sure that:

1. an appropriate Claim form is used

2. the contract number shown on the form is identical to the number on the Identification 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, whether on the Claim form or on the attached statement

6. the date of service (date of Admission to a Hospital or other Provider) or date of treatment is correct

7. the Provider includes a diagnosis code and a procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)

8. the Claim is completed and signed by You and the Provider.

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

D. Additional Information For Filing Specific Claims

1. Admission to a Hospital or Allied Health Facility Claims

   When You or an enrolled Member of Your family is being admitted to a Preferred or Participating Provider, show the ID card to the admitting clerk. The Provider will file the Claim with Us. Our payments will go directly to the Preferred or Participating Provider.

   The Provider will then bill You directly for any remaining balance. You will receive an Explanation of Benefits after the Claim has been processed.

2. Emergency Room or Outpatient Department Claims

   The procedure to be followed is the same as that for an Admission to a Hospital or Allied Health Facility.

However, in some instances involving Emergencies or Outpatient treatment the Provider may ask for payment directly from You. If this occurs, obtain an itemized copy of the bill; be sure the Claim form correctly notes the contract number, the patient's date of birth, as well as the patient's relationship to the Subscriber. The Provider must mark the statement or Claim form PAID. Forward this statement to Blue Cross and Blue Shield of Louisiana.

3. 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 the ID card to the Participating Pharmacist. However, if You must file a Claim to access Your Prescription Drug Benefit, You must use the Prescription Drug Claim form. Members may obtain the Prescription Drug Claim form by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy**. 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 Blue Cross and Blue Shield of Louisiana's Pharmacy Benefit Manager, whose telephone number should be found on the ID card. Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug.

4. Other Medical Claims

When You receive other medical services (clinics, Provider offices, etc.) You should ask if the Provider is a Preferred or Participating Provider. If yes, this Provider will file Your Claim with Us. In some situations, the Providers may request payment and ask You to file. If this occurs be sure the Claim form is complete before forwarding to Blue Cross and Blue Shield of Louisiana. If You are filing the Claim the Claim must contain the itemized charges for each procedure or service.

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

(a) full name of patient

(b) date(s) of service

(c) description of and procedure code for service

(d) diagnosis code

(e) charge for service

(f) name and address of Provider of service.

E. If You Have A Question About Your Claim

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.

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

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.

*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
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

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

B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S.22:2081 et seq. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

C. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state; unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

D. Exclusion from Coverage

1. A person who holds a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

   a. he is eligible for protection under the laws of another state;

   b. the insurer was not authorized to do business in this state;

   c. his policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined by law, or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

   a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

   b. any policy of reinsurance (unless an assumption certificate was issued);

   c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;

   d. dividends, premium refunds, or similar fees or allowances described under the law;

   e. credits given in connection with the administration of a policy by a group contract holder;

   f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;

   g. unallocated annuity contracts (which give rights to group contract holders, not individuals), except if qualified by law

   h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;

   i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", or "Medicare Part D coverage" and any regulations issued pursuant to those parts;

   j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

E. Limits on Amounts of Coverage

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.

2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

   a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.

   b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.

   c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

3. In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

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

Nondiscrimination Notice
Discrimination is Against the Law

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

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

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

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

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

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

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

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

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

Or

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

01MK6445 9/16

Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc., and Southern National Life Insurance Company, Inc., are subsidiaries of Blue Cross and Blue Shield of Louisiana. All three companies are independent licensees of the Blue Cross and Blue Shield Association.

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, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈໍາຕົວຂອງທ່ານ. 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)