Bridge Blue

POINT OF SERVICE BENEFIT PLAN
SHORT-TERM MEDICAL

HMO Louisiana

Bridge Blue is a product of HMO Louisiana, Inc., a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross Blue Shield Association.

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Thank You for choosing Us!

It is my pleasure to welcome You to Your new policy. If You are renewing Your policy, 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 Policy 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,

Bryan R. Camerlinck
President and Chief Executive Officer

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.

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.

THIS IS A LIMITED BENEFIT POLICY. READ CAREFULLY.

BRIDGE HMO LOUISIANA, INC. POINT OF SERVICE
SHORT TERM MEDICAL POLICY

NOTICES

This Policy 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.

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

This policy	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders.	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	May people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

THIS POLICY IS SUBJECT TO CANCELLATION OR NON-RENEWAL AT THE OPTION OF THE INSURER.

If You decide that You do not want this Policy, You may return it within ten (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 OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT **WWW.BCBSLA.COM** OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

YOUR SHARE OF THE PAYMENT FOR HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

We base Our payment of Benefits for Your Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom You receive Covered Services.

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

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 selected by You in consultation with Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any applicable Copayments, Deductible Amounts and Coinsurances.

Important information regarding this Policy will be sent to the mailing address You provided on the application for coverage. **You are responsible for keeping Us informed of any changes in Your address of record.**

REQUIREMENT TO SELECT A PRIMARY CARE PHYSICIAN (PCP)

This coverage requires You to designate a Primary Care Physician. You have the right to designate any PCP who participates in Your Network and who is available to accept You. Until You make this designation, We designate one for You. For information on how to select a PCP, and for a list of the PCP in Your Network, visit **www.bcbsla.com** or call the customer service phone number on the ID card. Additional information about Your PCP selection can be found in the Understanding the Basics of Your Coverage section of this Policy.

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

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

This Policy covers Prescription Drugs and uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Policy. Drugs that are not listed on the formulary, also called non-formulary drugs, are not covered. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers.

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

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

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

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

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

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

What's in this Policy?

ARTICLE 1. UNDERSTANDING THE BASICS OF YOUR COVERAGE 4
ARTICLE 2. DEFINITIONS 12
ARTICLE 3. SCHEDULE OF ELIGIBILITY 27
ARTICLE 4. BENEFITS 27
ARTICLE 5. HOSPITAL BENEFITS 31
ARTICLE 6. MEDICAL AND SURGICAL BENEFITS 32
ARTICLE 7. PRESCRIPTION DRUG BENEFITS 35
ARTICLE 8. PREVENTIVE OR WELLNESS CARE.................................... 39
ARTICLE 9. MENTAL HEALTH BENEFITS 47
ARTICLE 10. SUBSTANCE USE DISORDER BENEFITS.............................. 47
ARTICLE 11. ORAL SURGERY BENEFITS 47
ARTICLE 12. ORGAN, TISSUE, AND BONE MARROW TRANSPLANT BENEFITS 49
ARTICLE 13. PREGNANCY CARE 51
ARTICLE 14. REHABILITATIVE AND HABILITATIVE CARE BENEFITS 52
ARTICLE 15. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT............ 54
ARTICLE 16. CARE MANAGEMENT 67
ARTICLE 17. LIMITATIONS AND EXCLUSIONS.. 72
ARTICLE 18. GENERAL PROVISIONS.. 81
ARTICLE 19. COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES 93
ARTICLE 20. MAKING POLICY CHANGES AND FILING CLAIMS 97

ARTICLE 1. UNDERSTANDING THE BASICS OF YOUR COVERAGE

HMO Louisiana, Inc. issues this health Policy to You, the Subscriber named on the Schedule of Benefits. As of the Effective Date or amended Effective Date shown on the Schedule of Benefits, We agree to provide the Benefits specified in this Policy for You. This Policy replaces any others previously issued to You, as of the amended Effective Date.

This Policy describes Your Benefits, as well as Your rights and responsibilities under this coverage. We encourage You to read this Policy carefully.

Call Us if You have questions about Your coverage or any limits to the coverage. Many sections of this Policy are related to other sections of the Policy. You may not have all of the information You need by reading just one section. Be aware that Your Physician does not have a copy of Your Policy 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 Policy. We, Us and Our means HMO Louisiana, Inc. You, Your and Yourself means the Subscriber. Capitalized words are defined terms in the Definitions Article 2 of this Policy. A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

A. Facts About this Short Term Medical Policy

This is a Short Term Medical Policy. Your coverage is for a specific coverage period, shown on the Schedule of Benefits. This Policy may be renewed or extended at the sole discretion of the Company to the extent permitted by applicable law. It is not guaranteed renewable or extendable.

<u>Network Provider</u>

You have an extensive Network of Providers available to You – the HMOLA Network (Network). You can get care from Providers who are not in Your Network, but Benefits will be paid at a lower level.

<u>Non-Network Provider</u>

A Non-Network Provider is one of two types – Participating or Non-Participating.

1. Participating Providers are those Providers who have signed Provider agreements to participate in the Networks of Blue Cross and Blue Shield of Louisiana or another Blue Cross and Blue Shield Plan.
2. Non-Participating Providers are Providers who do not have a signed Provider agreement to participate in the HMOLA Network or any Blue Cross and Blue Shield Network.

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

For example, You will usually pay a Copayment to a Network Provider when You receive a service. If a Copayment is shown on the Schedule of Benefits, You must pay the Copayment amount to the Network Provider each time You receive the Covered Services listed. Most Benefits are subject to Your payment of a Deductible Amount. After payment of Deductible Amounts, Benefits are subject to two (2) Coinsurances (for example, 80/20, 60/40). Your choice of a Provider determines what Coinsurance applies to the service provided. You can go

outside the Network and obtain care from Providers who are not in the HMOLA Network. You will usually pay a Deductible Amount and Coinsurance when You receive care from Providers outside the Network. We will pay the highest Coinsurance level for Medically Necessary services when You go to a Provider in the HMOLA Network. We will pay the lower Coinsurance level when You receive Medically Necessary services from a Provider who is not in the HMOLA Network. Deductible Amounts and Coinsurances are stated on the Schedule of Benefits.

This is a direct access Policy. You may see Specialists in the HMOLA Network without contacting a Primary Care Physician or getting a referral from a Primary Care Physician.

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

B. Our HMOLA Provider Network

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

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

Network Benefits mean the highest level of Benefits payable under this Policy when You go to Providers in the HMOLA Network. Non-Network Benefits mean a lower level of Benefit if You go outside the HMOLA Network for care. To receive Network Benefits, always verify that a Provider is a current HMOLA Network Provider. Visit Our website at **www.bcbsla.com**, or call customer service at the number on the ID card to verify that a Provider is a current HMOLA Network Provider, or to request a paper Provider directory. Our Network may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas.

A Provider may be contracted with Us when providing services at one location, and may be considered a Non-Network Provider when giving services from another location. Always check Your Provider directory to verify that the services are in the HMOLA Network at the location where You are seeking care.

Additionally, Providers in the HMOLA Network may be contracted to perform certain Covered Services, but may not be contracted in the HMOLA Network to perform other Covered Services. When an HMOLA Network Provider performs services that the Network Provider is not contracted with Us to perform (such as certain High-Tech Imagining services or radiology procedures), Claims for those services will be adjudicated at the Non-Network Benefit level. Check Your Provider directory to verify that the services are In-Network when performed by the Provider or at the Provider's location.

We pay a lower level of Benefits when You go to a Provider outside the HMOLA Network. Benefits may also be based on a lower Allowable Charge. You will usually pay Deductible Amount and Coinsurance instead of a Copayment. Receiving care from a Non-Network Provider will result in higher costs to You. We recommend that You ask Non-Network Physicians or healthcare professionals about their billed charges before You receive care. Review the Sample Illustration of Your Costs When You Go to a Non-Participating Hospital before receiving care outside the Network. Emergency services performed in the Emergency department of a Hospital, even when the Hospital is not in Your Network, will be paid at the Network level of Benefits.

C. Obtaining Emergency and Non-Emergency Care Outside Louisiana and Around the World

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

In the United States:

Emergencies: You receive Network Benefits when covered Emergency Medical Services are provided in the Emergency department of a Hospital, regardless of Provider.

Non-Emergencies: You receive Non-Network Benefits when covered non-Emergency Medical Services are given outside Your Service Area. Because no HMO Louisiana, Inc. Service Area exists outside Louisiana, Covered Services given outside Louisiana are paid at the Non-Network Benefit level. If You obtain these services from a BlueCard® Provider, You may only have to pay Your Network amount since BlueCard® Providers will generally accept the Allowable Charge as payment in full for the service.

Outside the United States:

Emergencies: You receive Network Benefits when covered Emergency Medical Services are provided in the Emergency department of a Hospital, regardless of Provider.

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

How to Get Care Outside the Service Area:

In an Emergency, go directly to the nearest Hospital.

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

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

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

You must obtain any required Authorizations from HMO Louisiana, Inc.

D. Using a Primary Care Physician (PCP)

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

You pay the lowest Physician Copayment when obtaining care from a PCP. PCPs are family practitioners, general practitioners, internists, geriatricians, or pediatricians. PCPs may coordinate healthcare needs from Consultation to hospitalization, direct You to an appropriate Provider when necessary, and assist in obtaining any required Authorizations.

The office visit Copayment may be reduced when services are rendered by a Provider participating in the Quality Blue program. Quality Blue Providers include any Provider who has signed a contract to participate in the Quality Blue program. Currently, Quality Blue Providers include family practitioners, general practitioners, pediatricians, internists, geriatricians, nurse practitioners and physician assistants, but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, You may review a Provider directory on Our website at **www.bcbsla.com** or contact Our customer service department at the number on the ID card.

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

E. Authorizations

Some services and supplies require Authorization from Us before services are obtained. The Schedule of Benefits lists the specific services, supplies, and Prescription Drugs that require Authorization. For more information on those items and services that require Authorization visit the website, **www.bcbsla.com/priorauth**. See the Care Management Article of this Policy for additional information regarding Authorization requirements.

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

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

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

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

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

When the Member uses Network Providers

Network Providers have signed a contract with Us to participate in the HMO Louisiana, Inc. Network. These Providers have agreed to accept the lesser of billed charges or the amount negotiated amount as payment in full for Covered Services. 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 in the Network column on the Schedule of Benefits for these services.

When the Member uses Participating Providers

Participating Providers have not a signed a contract with Us to participate in the HMOLA Network, but have signed contracts with Blue Cross and Blue Shield of Louisiana 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 seventy-five (75) mile radius of the Member's home. To file an Appeal, the Member must follow the Appeal procedures in this Policy.

When the Member uses Non-Participating Providers

Non-Participating Providers do not have a signed contract with the HMOLA Network, with Blue Cross and Blue Shield of Louisiana, 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 the lesser of the following as determined by Us:

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

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

3. the Provider's billed charge. You will receive a lower level of Benefit because You did not go to a Network Provider.

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

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

SAMPLE ILLUSTRATION OF MEMBER COSTS WHEN CARE IS OBTAINED AT A NON-PARTICIPATING HOSPITAL

Note: The following example is for illustration purposes only and is not a true reflection of the Member's actual Copayments, Deductible Amounts and Coinsurances. Please refer to the Schedule of Benefits to determine Your actual 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 You go to the Hospital, have already met Your Deductible Amount, and have 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 Hospitals is $3,000 to render this service. There is no negotiated rate with the Non-Participating Hospital. You are responsible for all amounts not paid by Us, up to the Hospital's billed charge. This example illustrates Your costs at three different Hospitals for the same service.

The Member receives Covered Services from:	**HMOLA Hospital**	**Participating Hospital**	**Non-Participating Hospital**
	Network	**Non-Network**	**Non-Network**
Hospital Bill:	$12,000	$12,000	$12,000
Allowable Charge:	$2,500	$3,000	$2,500
We pay	$2,500 Allowable Charge X 80% Coinsurance **$2,000**	$3,000 Allowable Charge X 60% Coinsurance **$1,800**	$2,500 Allowable Charge X 60% Coinsurance **$1,500**
You pay	20% Coinsurance x $2,500 Allowable Charge **$500**	40% Coinsurance x $3,000 Allowable Charge **$1,200**	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 YOU PAY	**$500**	**$1,200**	**$10,500**

G. When a Member Purchases Covered Prescription Drugs

Some pharmacies have contracted with Us or with Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is

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 covered Prescription Drugs and the amount that You must pay for covered Prescription Drugs.

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

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

H. Mental Health and Substance Use Disorder Benefits

The Company has contracted with an outside company to perform certain administrative services related to Mental Health and substance use disorders Benefits for Members. For help with these Benefits, the Member should refer to the Schedule of Benefits, the ID card, or call Our customer service department.

I. Member Incentives and Value-Added Services

Sometimes We may offer You coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. We may offer You discounts or financial incentives to use certain Providers for selected Covered Services. We may also offer You the opportunity to enroll in health and non-health related programs, as value-added services, to enhance Your experience with Us or Your Providers. These incentives and value-added services are not Benefits and do not alter or affect Your Benefits. They may be offered by Us, affiliated companies, and selected vendors. You 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 You.

J. Health Management and Wellness Tools and Resources

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

K. Customer Service Email Address

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

L. Identity Protection Services

HMO Louisiana, Inc. is committed to identity protection for You. This includes protecting the safety and security of Your information. To support Our efforts, We offer 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; and
3. Fraud resolution support that assists You in addressing issues that arise in relation to credit monitoring and fraud detection.

You cease to be eligible for these services if health coverage is terminated during the Policy Term. If health coverage is terminated during the Policy Term, Identity Protection Services will be provided to the Member through the end of the Policy Term.

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

ARTICLE 2. DEFINITIONS

The inclusion of any definition in this Article does not denote that any particular benefit, condition, diagnosis, procedure, service, or treatment is covered under this Policy. Please review the Policy in its entirety to determine Your coverage.

Accidental Injury – A condition that directly results from a traumatic bodily injury sustained only through accidental means from an external force. Injuries caused by chewing, biting, clenching, or grinding of teeth are not accidental injuries to teeth. If Benefits are available to treat a particular injury, Your Policy will cover an injury that results from an act of domestic violence.

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

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

A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is considered experimental or Investigational;

B. Your eligibility for coverage under the Policy;

C. Any prospective or retrospective review determination; or

D. A Rescission.

Allied Health Facility – An institution other than a Hospital that the appropriate state agency licenses, where required, or that We approve to give Covered Services.

Allied Health Professional – A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, or approved by Us to give Covered Services. For this Policy, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified midwives, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, physician assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as state law mandates for specified services, if We approve them to give Covered Services.

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

Allowable Charge –

A. For Network Providers - The lesser of the billed charge or the amount We establish or negotiate as the maximum amount allowed for services from these Providers covered under this Policy.

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

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

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

   3. the Provider’s billed charge.

Alternative Benefits – Benefits for services that this Policy does not routinely cover but may provide by agreement through Case Management.

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

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of Physicians. This type of center has permanent facilities that are equipped and operated mainly to perform Surgical procedures. A center has continuous Physician and registered professional nursing services available whenever patients are in the facility, does not provide services or other accommodations for patients to stay overnight, and offers the following services whenever patients are in the center;

A. Anesthesia services as needed for medical operations and procedures performed;
B. Provisions for patient's physical and emotional well-being;
C. Provision for Emergency Medical Services;
D. Organized administrative structure; and
E. Administrative, statistical and medical records.

Appeal – A written request from You or Your authorized representative to change an Adverse Benefit Determination We made.

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

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

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

Bed, Board and General Nursing Service – Room accommodations, meals and all general services and activities that Hospital employees provide to care for patients. This service includes all nursing care and nursing instructional services provided as a part of the Hospital's bed and board charge.

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

Benefit Period – The period beginning on the Effective Date and continuing up to a maximum of eleven (11) months, as stated on the Schedule of Benefits.

Bone Mass Measurement – A radiologic or radioisotopic procedure or other scientifically proven technologies performed on someone to identify bone mass or detect bone loss.

Brand-Name Drug – A patented Prescription Drug that the original drug manufacturer markets after the Food and Drug Administration (FDA) approves it, or that We identify as a Brand-Name product. We classify drugs as Brand-Name Drugs based on a nationally recognized pricing source. We may not classify the same drugs as Brand-Name Drugs that manufacturers or pharmacies do.

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

Case Management – A method of delivering patient care that emphasizes quality patient outcomes with efficient and cost-effective care. The process systematically identifies high-risk patients and assesses opportunities to coordinate and manage their total care to ensure the best health outcomes. Medical professionals provide these services and they focus on unusually complex, difficult or catastrophic illnesses. We choose when to offer Case Management services to You. Working with Your Physicians and with Your consent or the consent of Your family or caregiver, Our Case Management staff will manage care to achieve the most efficient and effective use of resources.

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

Chiropractic Services – Diagnosing conditions associated with the functional integrity of the spine and treating those conditions by adjusting, manipulating, and using physical and other properties of heat, light, water, electricity, sound, massage, therapeutic exercise, mobilization, mechanical devices such as mechanical traction and mechanical massage, and other rehabilitative measures to correct interference with normal nerve transmission and expression.

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

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

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

Company – HMO Louisiana, Inc. (HMOLA).

Complaint – An oral expression of dissatisfaction with a service.

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

Concurrent Care – Hospital Inpatient medical and Surgical care that a Physician who is not the attending Physician gives:

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

B. because the patient's condition is medically complex and requires more medical care.

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

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

Consultation – Another Physician's opinion or advice about Your evaluation or treatment which is given after the attending Physician asks for it. Consultations do not include the following:

A. those that Hospital rules and regulations require,

B. anesthesia consultations,

C. routine consultations for clearance for Surgery, or

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

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

Copayment (Copay) – The specific dollar amount You must pay when You receive Covered Services. For that dollar amount, see the Schedule of Benefits. Your Network Provider may collect the Copayment directly from You.

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

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

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

A. Short Term Medical Policies,

B. Specific disease policies (such as cancer policies),

C. Supplemental coverage (such as Medicare supplement),

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

E. Coverage for onsite medical clinics or coverage as specified in federal regulation under which Benefits for medical care are secondary or incidental to the insurance Benefits).

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

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

B. Acting as companion or sitter;

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

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

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

We determine which services are Custodial Care.

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

Deductible Amounts –

A. **Benefit Period Deductible Amount** — How much You must pay in the applicable Benefit Period for Covered Services before We pay Benefits. You pay separate Benefit Period Deductibles for Network and Non-Network categories. See the Schedule of Benefits for the specific dollar amounts of the Benefit Period Deductible. A separate Deductible Amount may apply to certain Covered Services if shown as applicable on the Schedule of Benefits.

B. **Pregnancy Care Deductible Amount –** How much You must pay in the applicable Benefit Period for Covered Pregnancy Care Services before We start paying Benefits for Pregnancy Care. See the Schedule of Benefits for the specific dollar amount of the Pregnancy Care Deductible. The Pregnancy Care Deductible Amount does not accrue to the Benefit Period Deductible Amount. Once the Pregnancy Care Deductible Amount is met, Coinsurance applies until the Out-of-Pocket Amount stated on the Schedule of Benefits is met.

C. **Prescription Drug Deductible Amount** — How much You must pay in the applicable Benefit Period before paying a Prescription Drug Copayment or Coinsurance percentage. The Prescription Drug Deductible Amount is separate from the Benefit Period Deductible Amount and the Pregnancy Care Deductible Amount. See the Schedule of Benefits for the specific dollar amount of the Prescription Drug Deductible.

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

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

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

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

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

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

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

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

Emergency – See Emergency Medical Condition.

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

Emergency Medical Condition (or Emergency) – A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson who acts reasonably and possesses an average knowledge of health and medicine to believe that not receiving immediate medical attention could reasonably be expected to result in:

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

B. Seriously impairing bodily function; or

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

Emergency Medical Services – Those immediate, unscheduled medical services that are necessary to evaluate or treat an Emergency Medical Condition.

Expedited Appeal – 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 Your life or health or jeopardize Your ability to regain maximum function.

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

C. An Admission, availability of care, continued Hospital stay, or healthcare service while You are in the Emergency room, under observation, or receiving Inpatient care.

Expedited External Appeal – A request to have an Independent Review Organization (IRO) immediately review Our initial Adverse Benefit Determination for a service or treatment. This type of appeal involves any of the following:

A. A medical condition for which the time frame for completing a standard External Appeal would seriously jeopardize Your life or health or jeopardize Your ability to regain maximum function, or a decision to not Authorize continued services while You are currently in the Emergency room, under observation, or receiving Inpatient care.

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

External Appeal – A request to have an Independent Review Organization (IRO) review Our initial Adverse Benefit Determination or to change a final Adverse Benefit Determination given on Appeal. You or Your authorized representatives may ask for an External Appeal involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, or a Rescission.

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

Generic Drug – A Prescription Drug that is equivalent to a Brand-Name Drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use; or that We identify as a Generic Drug. Based on a nationally recognized pricing source, We classify Prescription Drugs as Generic Drugs. Manufacturers or pharmacies do not classify them for Us. We may not classify the same drugs as Generic Drugs manufacturers or pharmacies do.

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

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

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

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

Hospice Care – An integrated set of services and supplies designed to provide palliative and supportive care to meet Your special needs and those of Your family during the final stages of terminal illness. A Physician directs an interdisciplinary team that centrally coordinates the full scope of health services. Hospice Care agency that We approve provides the services and supplies.

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

Imaging Services –

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

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

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

Independent Review Organization (IRO) – An Independent Review Organization that conducts external reviews of Our final Adverse Benefit Determinations. The IRO is not affiliated with Us and its decision is binding on both You and Us.

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

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

Inpatient – A Member who is admitted to a Hospital as a registered bed patient for whom a Bed, Board, and General Nursing Service charge is made. An Inpatient's medical symptoms or condition must require a Physician or nurse to intervene continuously, twenty-four (24) hours a day. If the services can be safely provided as an Outpatient, You do not meet the criteria for an Inpatient.

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

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

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

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

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

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

    3. Reference to federal regulations.

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

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

A. According to nationally accepted standards of medical practice;

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

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

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

Member – See Subscriber.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to:

A. psychoses;

B. neurotic disorders;

C. personality disorders;

D. affective disorders;

The specific severe mental illnesses defined by La. R.S. 22:1043:

E. schizophrenia or schizoaffective disorder;

F. bipolar disorder;

G. panic disorder;

H. obsessive-compulsive disorder;

I. major depressive disorder;

J. anorexia and bulimia;

K. intermittent explosive disorder;

L. post-traumatic stress disorder;

M. psychosis NOS when diagnosed in a child under 17 years of age;

N. Rett's Disorder;

O. Tourette's Disorder; and

P. unless otherwise determined by Us, 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 as determined by the Company.

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

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

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

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

Non-Network Benefits – Benefits for care You receive from Non-Network Providers. We also call Non-Network Benefits Out-of-Network.

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

Occupational Therapy – Evaluating and treating physical injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by the use of specific goal-directed activities, therapeutic exercises, or other interventions that alleviate impairment or improve functional performance. These can include:

A. designing, fabricating, or applying Orthotic Devices;

B. training in using Orthotic Devices and Prosthetic Devices;

C. designing, developing, adapting or training in using assistive devices; and

D. adapting environments to enhance functional performance.

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

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

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

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

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

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

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

Policy – This agreement, including the Application for Short Term Medical Coverage, Schedule of Benefits, amendments, and any endorsements that entitle You to Benefits.

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

Policy Maximum – The maximum amount of Allowable Charges to be paid by the Company for covered Claims incurred during the Policy Term as shown on the Schedule of Benefits.

Policy Term – The period that is up to a maximum of eleven (11) months, beginning at 12:00 a.m. on the Effective Date and ending at 11:59 p.m. on the termination date stated on the Schedule of Benefits.

Pregnancy Care – Treatment or services related to all care before delivery, during delivery, after delivery, and any Complications that occur from each pregnancy.

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

Prescription Drug Coinsurance – The sharing of Allowable Charges for Prescription Drugs. The sharing is expressed as a pair of percentages; a Company percentage that We pay and a Member percentage that You pay. Once You have met any applicable Prescription Drug Deductible Amount, Your percentage will be applied to the Allowable Charges for Prescription Drugs to determine Your financial responsibility. Our percentage will be applied to the Allowable Charges for Prescription Drugs to determine the Benefits provided. A different Prescription Drug Coinsurance may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

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

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

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

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

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage, or adoption. 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 or Device – Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part. Limb prostheses are artificial limbs that are designed to maximize patients' function, stability, and safety; that are not Surgically implanted; and that are used to replace a missing limb. Limb Prosthetics do not include artificial eyes, ears, nose, dental appliances, ostomy products, or devices such as eyelashes or wigs.

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

Provider – A Hospital, Allied Health Facility, Physician, or Allied Health Professional that We approve, is licensed where required, and performs within the scope of that license. If a Provider does not have a state or federal license, We have the right to define all criteria under which a Provider's services may be offered to Our Members for Benefits to apply to a Provider's Claims. If Providers who do not meet these criteria submit Claims, We will be not pay them.

A. **HMOLA Provider** – A Provider who has signed a contract with Us to participate in the HMOLA Network. This Provider is also referred a Network Provider or In-Network Provider.

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

C. **Non-Participating Provider** – A Provider who has not signed a contract with HMOLA, Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Skilled Nursing Facility or Unit – A facility licensed by the state in which it operates and is not a nursing home or a unit within a Hospital (unless We approved skilled nursing in the nursing home or unit within a Hospital). The facility provides:

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

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

C. Twenty-four hour nursing service by registered nurses or licensed practical nurses; and

D. Utilization review plans for all patients.

Sound Natural Tooth – A healthy natural tooth that is functioning in the mouth; is organically formed by natural development of the body (not artificial or manufactured); is not predisposed to injury due to extensive restoration, disease, or decay; and has at least fifty percent (50%) bony support. Examples of teeth that are not Sound Natural Teeth are teeth that are included in bridges, have received root canal treatment, have extensive restoration or restorative material, or have caps and/or crowns.

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

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

Specialty Drugs – Specialty Pharmaceuticals are typically high in cost and have one (1) or more of the following characteristics:

A. Required specialized patient training on administering the drug (including supplies and devices needed for administration) is required;

B. Required coordination of care before drug therapy starts or during therapy;

C. Unique patient compliance and safety monitoring requirements;

D. Unique requirements for handling, shipping, and storing the drug; and

E. Restricted access or limited distribution.

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

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

Subscriber / Member – Someone who is a resident of this state, who has satisfied the specifications in the Schedule of Eligibility, who has signed the Application for Short Term Medical Coverage or had an appropriate legal representative sign the application, who has enrolled for coverage, and to whom We have issued this Policy.

Surgery –

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

B. The correction of fractures and dislocations.

C. Pregnancy Care, including vaginal deliveries and cesarean sections.

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

E. Other procedures as defined and approved by Us.

Telehealth Services – A mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from healthcare Providers approved by Us to render Telehealth Services. Telehealth Services give Providers the ability to render services to be accessed when the Provider and patient are in separate locations.

A. **Asynchronous Telehealth Services –** the transmission of a patient's pre-recorded medical information from an originating site to the Provider at a distant site without the patient being present.

B. **Synchronous Telehealth Services –** the interaction between patient and Provider in different locations in real time, by means of two-way video and audio transmission, usually through an established patient portal.

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

Temporomandibular Joint (TMJ) Disorder – Disorders resulting in pain or dysfunction of the temporomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes. Temporomandibular Joint (TMJ) Disorders do not include pain or dysfunction of the temporomandibular joint caused by acute dental conditions (e.g., caries or periodontal disease), acute and chronic sinus disease, carotidynia, cervical spine pathology, disorders of the salivary glands, otologic (ear) disorders, neuralgias of the head and neck, and headache syndromes (migraine, cluster and/or tension). Note that the exclusion of the foregoing listed conditions from the definition of Temporomandibular Joint (TMJ) Disorders does not necessarily mean those listed conditions are Covered Services under this Policy.

Termination Date – The date this policy ends, unless renewed or extended.

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

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

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

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

ARTICLE 3. SCHEDULE OF ELIGIBILITY

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

A. Eligibility

1. **Subscriber/Member** – A Subscriber/Member is someone who has signed the Application for Short Term Medical Coverage, or someone on whose behalf an application has been signed by the appropriate legal representative, and which We have accepted coverage. You must be a Louisiana resident when You apply and while covered.

B. Effective Date of Coverage

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

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

3. We may require applicant to pay Us all past due amounts from previous coverage before agreeing to accept the applicant for coverage on this Policy.

ARTICLE 4. BENEFITS

ANY BENEFIT LISTED IN THIS POLICY THAT IS NOT MANDATED BY STATE OR FEDERAL LAW MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.

A. Benefit Categories

1. **Network Benefits (In-Network)** – Benefits for medical care received from an HMO Louisiana, Inc. Provider. When a Member receives care from a Network Provider, the Member will receive the highest level of Benefits under this Policy.

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

B. Deductible Amounts

1. Subject to the Deductible Amounts shown on the Schedule of Benefits, the maximum limitations provided, and other terms and provisions of this Policy, We will provide Benefits according to the Coinsurance

percentage shown on the Schedule of Benefits toward Allowable Charges incurred for Covered Services by You during a Benefit Period. The following Deductibles may apply to Benefits provided by this Policy.

a. **Benefit Period Deductible Amount**: How much You must pay in the applicable Benefit Period for Covered Services before We pay Benefits. You pay separate Benefit Period Deductibles for Network and Non-Network categories. See the Schedule of Benefits for the specific dollar amounts of the Benefit Period Deductible. A separate Deductible Amount may apply to certain Covered Services if shown as applicable on the Schedule of Benefits.

b. **Pregnancy Care Deductible Amount**: How much You must pay in the applicable Benefit Period for Covered Pregnancy Care Services before We start paying Benefits for Pregnancy Care. See the Schedule of Benefits for the specific dollar amount of the Pregnancy Care Deductible. The Pregnancy Care Deductible Amount does not accrue to the Benefit Period Deductible Amount. Once the Pregnancy Care Deductible Amount is met, Coinsurance applies until the Out-of-Pocket Amount stated on the Schedule of Benefits is met.

c. **Prescription Drug Deductible Amount**: How much You must pay in the applicable Benefit Period before paying a Prescription Drug Copayment or Coinsurance percentage. The Prescription Drug Deductible Amount is separate from the Benefit Period Deductible Amount and the Pregnancy Care Deductible Amount. See the Schedule of Benefits for the specific dollar amount of the Prescription Drug Deductible.

2. Each of the Deductible Amounts listed on the Schedule of Benefits must be met for each Benefit Period. You may have separate Network and Non-Network amounts. Amounts that apply to a Network Deductible do not apply to a Non-Network Deductible. Amounts that apply to a Non-Network Deductible do not apply to a Network Deductible.

3. We will apply Your Claims to the appropriate Deductible Amount in the order in which Claims are received and processed. It is possible that one Provider may collect the Deductible Amount from 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 to whom the overpayment was made.

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

C. Coinsurance Amount

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

D. Copayment Services

The Member may pay one or more Copayments each time applicable Covered Services are rendered. The amount of the Copayment depends on the service and the type of Network Provider rendering the service. Office visit Copayments, if applicable, will be shown on the Schedule of Benefits.

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

1. Examples of Covered Services subject to Copayments:

   a. Office visits and consultations;

   b. Surgical procedures performed in the Physician’s office; and

   c. Diabetes education.

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

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

   b. Allergy testing;

   c. Anesthesia;

   d. Chemotherapy;

   e. Radiation treatment;

   f. Low-Tech Imaging;

   g. Lab tests;

   h. Dialysis;

   i. Infusion therapy; and

   j. Medical and Surgical supplies.

E. Out-of-Pocket Amount

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

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

   a. Deductible Amount;

   b. Prescription Drug Deductible Amount;

   c. Coinsurance; and

d. Copayments.

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

   a. Pregnancy Care Deductible Amount;

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

   c. any penalties You or the Provider must pay; and

   d. charges for non-Covered Services.

ARTICLE 5. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-Emergency, Emergency, Pregnancy Care, Mental Health and substance use disorders 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 as well as the level of care.

You must pay all Copayments, Deductible Amounts, and Coinsurance shown on the Schedule of Benefits. If You receive services from a Physician in a Hospital-based clinic, You may be subject to charges from the Physician or clinic as well as the facility.

If You go to a Hospital Emergency room for an Emergency Medical Condition, and You are admitted to the Hospital, the Inpatient Admission must be Authorized.

If You are medically stable and admitted to a Non-Network Hospital, Benefits will be processed at the Non-Network Deductible Amount and Coinsurance shown on the Schedule of Benefits.

If You are not medically stable and admitted to a Non-Network Hospital, Benefits will be processed at the higher Community Blue Network Deductible Amount and Coinsurance shown on the Schedule of Benefits. However, once stabilized, You must move to a Community Blue Network Hospital.

You may also be balanced billed by a Non-Participating Hospital.

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 if You are critically ill and require an intensive level of care.

3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us.

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

B. Other Hospital Services (Inpatient and Outpatient)

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

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

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

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

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

6. Diagnostic Services rendered by a Hospital employee.

7. Physical Therapy provided by a Hospital employee.

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

C. Pre-Admission Testing

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

ARTICLE 6. MEDICAL AND SURGICAL BENEFITS

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

A. Surgical Services

1. Surgery

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

   b. The pre-operative and post-operative period is defined and determined by Us and is that period of time which is appropriate as routine care for the particular Surgical procedure.

   c. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

2. Multiple 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 primary service as determined by Us.

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

d. Unbundled Services

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

(2) The Allowable Charge of 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.

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

3. Assistant Surgeon

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

4. Anesthesia

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.

Anesthetic or sedation procedures performed by the operating Physician, an assistant surgeon, or an advanced practice registered nurse will be covered as a part of the Surgical or diagnostic procedure unless We determine otherwise.

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

5. Second Surgical Opinion

   Benefits are available for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. The Physician that provides a second or third opinion must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory to receive Benefits.

B. Inpatient Medical Services

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

1. Inpatient medical care visits;

2. Concurrent Care; and

3. Consultation (as defined in this Policy).

C. Outpatient Medical and Surgical Services

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

2. Consultation (as defined in this Policy).

3. Diagnostic Services.

4. Services of an Ambulatory Surgical Center.

5. services of an Urgent Care Center.

D. Classification of Benefits as Medical Surgical (MS) Benefits Versus Mental Health/Substance Use Disorder (MH/SUD) Benefits

1. Benefits shall be categorized as either Medical/Surgical (MS Benefits) Benefits or Mental Health (MH) and Substance Use Disorder (SUD) Benefits (collectively termed MH/SUD Benefits) according to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

2. Specific Benefits offered and services provided may be mapped to either category of MS Benefits or MH/SUD Benefits depending on the diagnosis.

3. For purposes of the classification, the following definitions are applicable:

   a. Medical/Surgical (MS) Benefits – Benefits with respect to items or services for medical conditions or Surgical procedures, as defined under the terms of the Contract, and in accordance with applicable federal and state law, but not including MH/SUD Benefits.

   b. Mental Health/Substance Use Disorder (MH/SUD) Benefits – Mental Health (MH) Benefits with respect to items or services for mental health conditions, as defined under the terms of the Policy and in accordance with applicable federal and state law. Substance Use Disorder (SUD) Benefits mean benefits with respect to items or services for substance use disorders, as defined under the terms of the Policy and in accordance with applicable federal and state law. MH/SUD Benefits include conditions and diseases listed in the most recent edition of the International Statistical Classification of Diseases and Related Health Problems (ICD)

as psychotic disorders, mood disorders, stress-related disorders, personality and mental retardation; other nonpsychotic mental disorders listed in the ICD, to be determined by Us; or disorders listed in the ICD requiring treatment for misuse or dependence upon substances such as alcohol, narcotics, or hallucinogens.

ARTICLE 7. PRESCRIPTION DRUG BENEFITS

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

A. The Prescription Drugs Must Be Dispensed Properly

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

B. Some Pharmacies Have Contracted with Us

Some pharmacies have contracted with Us or with Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are Participating Pharmacies.

Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount We pay Our Pharmacy Benefit Manager to base Our payment for Your Covered Prescription Drugs and the amount that You must pay for covered Prescription Drugs.

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

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

When buying covered Prescription Drugs at a Network Pharmacy, present a valid ID card. The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. If You have not met Your Prescription Drug Deductible Amount, the Network Pharmacy may collect 100% of the discounted costs of the drug at the point of sale. If You have met Your Prescription Drug Deductible Amount, You will pay the Copayment or Coinsurance shown on the Schedule of Benefits. The Network Pharmacy will electronically submit the Claim for You.

D. Prescription Drug Formulary

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

are included on the formulary, Our Drug Utilization Management Program, more fully described in the section below, may apply.

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

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

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

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

Option 1 – Prescription Drug Benefits (3 Tier)

1. The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. You may be required to pay a different Copayment or Coinsurance depending on whether Your Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

2. The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. You may call customer service or go to **www.bcbsla.com/pharmacy** to identify the tier classification of Your Prescription Drug.

3. If a formulary exception request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary at the highest drug tier (Member cost share amount).

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

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

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

Option 2 – Prescription Drug Benefits (2 Tier)

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

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

   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 or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available at **www.bcbsla.com/pharmacy** or by calling customer service at the number on the ID card. If the Prescription Drug requires prior Authorization, Your Physician must call Medical Authorization at the number on the ID card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.

2. **Safety checks** – Before Your prescription is filled, Our Pharmacy Benefit Manager or We perform quality and safety checks for usage precautions, drug duplication, and frequency of refills (for example, refill before 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. Quantity Per Dispensing Limits/Allowances are based on the following:

   a. the manufacturer's recommended dosage and duration of therapy;

   b. common usage for episodic or intermittent treatment;

   c. FDA-approved recommendations and clinical studies; or

   d. as determined by Us.

4. **Step Therapy** –Certain drugs and drug classes are subject to Step Therapy. In some cases, We may require You to first try one (1) or more Prescription Drugs to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat Your medical condition, We may require Your Physician to prescribe Drug A first. If Drug A does not work for You, 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 (72) hours unless exigent circumstances exist, in which case We will respond to the request within twenty-four (24) 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

This Policy covers select diabetic supplies, including, but not limited to, necessary continuous glucose monitors and associated supplies, insulin syringes and test strips under the Prescription Drug Benefit.

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

When You buy covered Prescription Drugs from a pharmacy that has contracted with Us or with Our Pharmacy Benefit Manager or when You file a paper Claim with Us or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that We pay Our Pharmacy Benefit Manager for covered Prescription Drugs.

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

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

I. We May Disclose Information About Your Prescription Drug Usage

As part of Our administration of Prescription Drug Benefits, We may disclose information about Your Prescription Drug utilization, including the names of Your prescribing Physicians, to any treating Physicians or dispensing pharmacies.

J. We Use Any Savings or Rebates to Stabilize Rates

Any savings or rebates We receive on the cost of drugs purchased under this Policy from drug manufacturers are used to stabilize rates.

ARTICLE 8. PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to You upon the effective date required for the coverage. If You receive Preventive or Wellness Covered Services from a Network Provider, Benefits will be paid at 100% of the Allowable Charge. When Preventive or Wellness Care Covered Services are rendered by a Non-Network Provider, Benefits will be subject to Copayment (if it applies) and Coinsurances shown on the Schedule of Benefits. The Benefit Period Deductible Amount will apply to Covered Services received from a Non-Network Provider, unless otherwise stated below. Preventive or Wellness Care services may be subject to other limitations shown on the Schedule of Benefits.

PREVENTIVE or WELLNESS CARE SERVICES	AGE / CRITERIA
EXAMINATIONS AND TESTING – ALL ADULTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (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 Benefit but may be covered under standard Benefits.	Adults: All Ages
Colorectal Cancer Screenings • Fecal Immunochemical Test (FIT) for Blood: One (1) per Benefit Period. • Flexible sigmoidoscopy: One (1) every five (5) years. • Colonoscopy: One (1) every ten (10) years. • Physician prescribed colonoscopy preparation medications: Limit of two (2) prescriptions for selected generic drugs. • Cologuard DNA Testing: One (1) per Benefit Period. • Computed Tomographic (CT) Colonography: One (1) every five (5) years. • Any additional screenings will be subject to Deductible Amounts and Coinsurance shown on the Schedule of Benefits. Services deemed Investigational are not covered.	 Ages 45 – 75 Ages 45 – 75 Ages 45 – 75 Ages 45 – 75 Ages 45 – 75 Ages 45 – 75
IMMUNIZATIONS – ALL ADULTS	
Immunizations recommended by Physician	Adults: All Ages
Seasonal Flu and H1N1 Immunizations	Adults: All Ages

SCREENINGS, COUNSELING AND SUPPLEMENTS – ALL ADULTS	
Anxiety/Behavioral/Social/Emotional Screening Limited to one (1) per Benefit Period.	All Ages
Blood Pressure Screenings • Office Blood Pressure Monitoring • Ambulatory Blood Pressure Monitoring (ABPM) • Home Blood Pressure Monitoring (HBPM) • Limit of one (1) per Benefit Period for services listed above. • Annual Blood Pressure Screening	Ages 18 and older 40 years or older and those at increased risk for high blood pressure
Cardiovascular Disease Counseling	Adults who are overweight or obese and have additional risk factors
Cholesterol Screening	Men: Ages 20 – 35 if at risk; or 35 and older Women: Ages 20 – 45 if at risk; or 45 and older
Depression and Suicide Screening	Adults: All Ages
Diet Counseling	Adults with hyperlipidemia and other risk factors
Fall Prevention Intervention	Ages 65 and older
Hepatitis B Screening	High risk adults
Hepatitis C Screening	Adults: Ages 18 – 79 years
HIV Screening and Counseling	Ages 15 – 65; younger or older if at increased risk
Lung Cancer Counseling	All Ages
Lung Cancer Screening	Ages 50 – 80 (per guidelines for smoking history)

Obesity Screening and Counseling: Twenty-four (24) visits per Benefit Period. Must use Network Provider to obtain benefit.	Adults with a body mass index higher than 30 kg/m^2
Sexually Transmitted Infections Counseling	Sexually active adults at increased risk
Skin Cancer Screening	Adults: All Ages
Syphilis Screening	Adults at increased risk
Latent tuberculosis infection (LTBI) screening	Asymptomatic adults 18 years and older at increased risk for infection
Tobacco Use Screening and Counseling	Adults: All Ages
Prediabetes and Type 2 Diabetes Screening	Persons who are overweight or obese
Unhealthy Alcohol Use Screening and Counseling	Adults: Ages 18 and older
Unhealthy Drug Use Screening	Adults: Ages 18 and older
COVERED SERVICES FOR FEMALES	
BRCA1 & BRCA2 Genetic Testing – Screening and Counseling	Women with family history of risk (per guidelines)
Breast Cancer Chemoprevention Counseling	Women at risk for breast cancer
Chlamydia Infection Screening	Women ages 24 and younger who are sexually active; older if at increased risk
Gonorrhea Screening	Women ages 24 and younger who are sexually active; older if at increased risk
Human Papillomavirus (HPV) DNA testing – Limit of one (1) every five (5) years. Testing may be completed alone or in conjunction with a routine pap smear.	Ages 30 – 65 years
Intimate Partner Violence Screening	Ages 1 – 50 years

Mammography Examination, including Breast Ultrasound • Annual mammogram for women with hereditary susceptibility or prior chest wall radiation • One Baseline Mammogram • Annual mammogram and access to supplemental imaging (Breast MRI) upon recommendation of Physician for women with >20% predicted lifetime risk • Annual mammogram and Supplemental imaging (breast ultrasound, then Breast MRI if breast ultrasound is inconclusive) if recommended by Physician for women with C and D breast density A breast ultrasound may be completed alone or in conjunction with a mammogram. See below for details on coverage of Breast MRIs.	Age 30+ Ages 35 -39 Age 35+ Age 40+
Breast MRIs • Annual Breast MRI for women with hereditary susceptibility or prior chest wall radiation • Access to supplemental imaging (Breast MRI) upon recommendation of Physician for women with >20% predicted lifetime risk • Supplemental imaging (Breast MRI if breast ultrasound is inconclusive) if recommended by Physician for women with C and D breast density • Annual Breast MRI if recommended by Physician for women with prior history of breast cancer under 50 years of age • Annual Breast MRI if recommended by Physician for women with prior history of breast cancer at any age with C and D breast density. Benefits will not be paid at one hundred percent (100%). The Deductible Amount, if applicable, will be waived. All other MRIs payable same as High-Tech Imaging Services. Prior Authorization may be required if shown on the Schedule of Benefits.	Age 25+ Age 35+ Age 40+
Obesity Prevention Counseling	Midlife women ages 40 to 60 years with normal or overweight body mass index (BMI) (18.5–29.9 kg/m2)
Osteoporosis Screening: One (1) per Benefit Period	Ages 65 or older; younger postmenopausal women at risk (per guidelines)

Permanent Sterilization Method	Women with reproductive capacity
Routine Gynecological or Obstetrical Care Visits	As age and developmentally appropriate
Routine Pap Smear – One (1) per Benefit Period	As age and developmentally appropriate
Sexually Transmitted Infections Counseling	Sexually active women
Urinary Incontinence Screening— Annually	Impacts activities and quality of life of women
Violence and Domestic Abuse Counseling – Annually	Women and adolescent females
COVERED SERVICES FOR PREGNANT FEMALES	
Anemia Screening	During pregnancy
Anxiety/Behavioral/Social/Emotional Screening Limited to one (1) per Benefit Period.	During pregnancy or the postpartum period
Bacteriuria Screening	During 12 – 16 weeks of gestation or at first prenatal visit
Breast Feeding Intervention	During pregnancy and after birth
Counseling for Healthy Weight & Weight Gain in Pregnancy	During pregnancy
Diabetes after Pregnancy Testing and Screening – Initial testing should ideally occur within the first year postpartum.	During the postpartum period for women with a history of gestational diabetes who are not currently pregnant and have not been previously diagnosed with type 2 diabetes
Electric and Manual Breast Pumps	During the postpartum period

Gestational Diabetes Testing and Screening	Asymptomatic pregnant women after 24 weeks of gestation
Hepatitis B Screening	During first prenatal visit
Hypertensive Disorders of Pregnancy Screening	Throughout the pregnancy
Lactation Counseling	During pregnancy and after each birth
Lactation Supplies for Machine Use Only Limit of eight (8) boxes for milk storage bags per Benefit Period.	During the postpartum period
Perinatal Depression Prevention: eighteen (18) counseling visits per Benefit Period	During pregnancy and up to 1 year postpartum for women who do not have a current diagnosis of depression but are at increased risk
Hypertensive Disorders of Pregnancy Screening	Throughout the pregnancy
Rh Incompatibility Screening	Pregnant women during 24 – 28 weeks of gestation if at risk or at first prenatal visit
Syphilis Screening	During pregnancy
Tobacco Use Screening and Interventions, with Expanded Counseling	During pregnancy
COVERED SERVICES FOR MALES	
Abdominal Aortic Aneurysm Screening: One-time (1) Screening	Men who have smoked: Ages 65 – 75 years

Prostate Cancer Screenings – • Routine digital rectal exam: Limited to one (1) per Benefit Period. • Prostate Specific Antigen (PSA) test: Limited to one (1) per Benefit Period. • Second visit: For follow-up treatment within 60 days after the visit if it is related to a condition that is diagnosed or treated during the visit and recommended by a doctor.	Ages 50 and older or as recommended by doctor for ages 40 – 49 years Ages 50 and older or as recommended by doctor for ages 40 – 49 years Older than 40 years
COVERED SERVICES FOR CHILDREN & ADOLESCENTS	
Routine Wellness Physical Examination – Routine wellness diagnostic tests ordered by Physician (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 Benefit but may be covered under standard Benefits.	Ages 1 year and older
Well baby care	Ages 1 and older as recommended by Physician for developmental milestones
Immunizations recommended by Physician	Ages 1 year and older
Seasonal Flu and H1N1 Immunizations	Ages 1 year and older
Alcohol and Drug Use Assessments	Ages 11 – 21 years
Anxiety/Behavioral/Social/Emotional Screening Limited to one (1) per Benefit Period.	Ages 0 – 21
Autism Screening	Ages 1 – 2 years
Behavioral Assessments	Ages 1 – 21 years
Blood Pressure Screening	Ages 1 – 17 years
Cervical Dysplasia Screening	Adolescent Girls: Ages 11 – 21 years
Chlamydia Infection Screening	Ages 24 and younger who are sexually active

Depression and Suicide Screening	Ages 12 – 18 years
Developmental Screening	Varied Intervals: Ages 1 – 3 years
Dyslipidemia Screening	Varied intervals beginning at 24 months
Gonorrhea Screening	Ages 24 and younger who are sexually active
Hearing Screening Limited to one (1) per Benefit Period.	Ages 1 – 21 years
Height, Weight and Body Mass Index Measurements	Ages 2 – 21 years
Hematocrit or Hemoglobin Screening	Varied intervals: Ages 1 – 21 years
Hepatitis B Screening	High risk adolescents
HIV Screening and Counseling	Adolescents
Intimate Partner Violence Screening	Ages 1 – 50 years
Lead Screening Limited to one (1) per Benefit Period.	Ages 1 – 6 years
Obesity Screening and Counseling Limited to fifty-two (52) visits per lifetime.	Ages 3 – 18 years
Oral Health Assessment	Varied intervals between 1 – 6 years
Sexually Transmitted Infections Counseling	Sexually active adolescents
Skin Cancer Counseling	Ages 1 – 24 years
Tobacco Use Screening and Counseling	School-aged children and adolescents
Tuberculosis Screening Limited to one (1) per Benefit Period.	Ages 1 – 21 years
Violence and domestic abuse counseling	As needed

Vision Screening Limited to one (1) per Benefit Period.	Ages 1 – 21 years

ARTICLE 9. MENTAL HEALTH BENEFITS

Benefits for the treatment of Mental Disorders are available. Treatment must be given by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for treating Mental Health do not include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and employment counseling. Coverage for Mental Health includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis as approved by Us.

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

ARTICLE 10. SUBSTANCE USE DISORDER BENEFITS

Benefits for treating substance use disorders are available. Treatment must be given by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Covered Services will be only those which are for treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and psychological dependency which develops with continued use. Coverage for substance use disorders includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis as approved by Us.

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

ARTICLE 11. ORAL SURGERY BENEFITS

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

A. Covered Services or Procedures

This Policy only covers the following services or procedures when determined by Us to be Medically Necessary:

1. Excision of tumors or cysts that do not originate from the teeth, gingiva (gums), and periodontal structures. Examples of covered tumors and cysts include salivary gland tumors or cysts and primary tumors of the mandible and maxilla, such as ameloblastoma and osteosarcoma. Cysts and tumors originating from the teeth, gingiva (gums), and periodontal structures, such as periapical cysts or abscesses and odontogenic

cysts or keratocysts, are not covered. Excision of inflamed tissue related to periodontal disease is not covered.

2. Extraction of teeth when there is complete bony impaction of each tooth to be extracted.

3. Dental care and treatment required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and Sound Natural Teeth when received within seventy-two (72) hours of the onset of the Accidental Injury. Treatment must be completed within twelve (12) months of the onset of the Accidental Injury to a Sound Natural Tooth to be covered. The damage must be the result of an Accidental Injury to a Sound Natural Tooth struck from outside the mouth as a result of major trauma, which does not include injury caused by chewing, biting, clenching, or grinding of teeth. Coverage is limited to extraction of teeth needed to avoid infection of teeth damaged in the Accidental Injury; suturing; reimplanting and stabilization of dislodged Sound Natural Teeth; repositioning and stabilization of partly dislodged Sound Natural Teeth; and appropriate plain film dental x-rays. If multiple treatment options exist, coverage will only be available for the least costly Medically Necessary treatment option.

   The definitions of Accidental Injury and Sound Natural Tooth are those set forth in Article 2 of this Policy.

4. Excision of exostoses or tori of the jaws and hard palate when required for the fitting of a covered denture.

5. Anesthesia in any non-Hospital setting (for example, an Allied Health Facility, Ambulatory Surgical Center, or Office), including general anesthesia (e.g., monitored anesthesia care) and conscious sedation, when used for Medically Necessary Covered Services or procedures and when rendered or supervised by a Provider with a dental degree and the requisite training. Local anesthesia is always considered incidental to the covered dental service or procedure and is not eligible for separate reimbursement. Anesthesia for dental services is only reimbursable under this Policy when performed in conjunction with a Medically Necessary dental service or procedure that is covered under this Policy. If treatments, services or procedures are covered under the Member's separate or standalone dental plan, if applicable, then anesthesia is not covered under this Policy for such treatments, services or procedures.

6. Anesthesia when rendered in a Hospital or outpatient surgical facility and for associated Hospital or facility charges when the Member's mental or physical condition requires dental treatment, services, or procedures to be rendered in a Hospital or outpatient surgical facility. Covered conditions include:

   a. Member is less than six (6) years old.

   b. Member has a severe disability including, but not limited to, epilepsy with a history of uncontrolled seizures; Mental Disorders or mental conditions such as autism or schizophrenia, Down syndrome, or severe cerebral palsy that have been documented in the Member's medical history by a Physician.

   c. Member has a serious underlying medical condition including, but not limited to, severe asthma; congestive heart failure; bleeding disorders that could lead to immediate or severe airway compromise; or conditions with known or suspected airway compromise that have been documented in the Member's medical history by a Physician.

   d. Requirement for immediate and comprehensive treatment that threatens the patency of the Member's airway.

   e. Requirement for significant restorative or surgical procedures that have not been able to be successfully provided to the Member using behavior guidance in the dental office, including communication techniques, parental presence or absence, nitrous oxide and oxygen inhalation, protective stabilization or oral sedation.

f. Local anesthesia for the Member is contraindicated because of acute infection, anatomic variations that prevent adequate anesthesia or allergies to the medication.

g. Other conditions in which a Physician has certified that general anesthesia in a Hospital setting is Medically Necessary for the Member or when other methods of behavior guidance in the dental office have been tried and documented to be unsuccessful for the Member, including communication techniques, parental presence or absence, nitrous oxide and oxygen inhalation, protective stabilization or oral sedation.

7. Coverage is not available for conditions not listed above. Coverage based solely on a Member's level of fear or anxiety about a procedure is not covered unless it is documented that in the Member's medical history that all other forms of behavior guidance noted above have been tried and failed. Because Temporomandibular Joint (TMJ) Disorders are not covered under this Policy, anesthesia for Temporomandibular Joint (TMJ) Disorders is also not covered under this Policy.Benefits are available for dental services not otherwise covered by this Policy, 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. Benefits for head and neck cancer patients are only available when a comprehensive dental evaluation for treatment of decay and abscesses was performed on the Member prior to the initiation of chemotherapy and/or radiation therapy. Benefits are only available for dental services that are not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies and those dental services are as likely to produce equivalent therapeutic or diagnostic results for diagnosing or treating patients' illness, injury or disease as the alternatives. To obtain more information on how to access these medical Benefits, call customer service at the number on the ID card and as to speak to a Case Manager.

8. Dental implants are only eligible for coverage when they are not primarily for personal comfort or convenience of patients or Providers and when the dental implants are not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies and are as likely to produce equivalent therapeutic results for restoring a patient to their baseline (i.e., pre-injury/pre-illness) status. Dental implants placed into previously radiated bone are excluded from coverage.

B. Coordination of this Section with Dental Contracts

If You have dental coverage in addition to this medical Policy, the dental benefits under the other coverage will be determined first. The Benefits under this medical Policy will be determined on a secondary basis and will be reduced, so that no more than the full amount of the Allowable Charge is paid under all policies covering the same Claim or service.

ARTICLE 12. ORGAN, TISSUE, AND BONE MARROW TRANSPLANT BENEFITS

Authorization is required for the evaluation of Your suitability for All Solid Organ and Bone Marrow Transplant procedures. For this Policy, all autologous procedures are considered transplants.

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

A. Acquisition Expenses

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

If any organ, tissue or bone marrow is sold rather than donated to You, 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 given by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or the HMO Louisiana, Inc. (HMOLA) approved facility, unless otherwise approved by Us in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To find an approved transplant facility, call customer service at the number on the ID card.

   The organ, tissue and bone marrow transplant Benefits are shown on the Schedule of Benefits and are not covered under the Non-Network Benefit category. Benefits are provided for Network services only.

2. Benefits for organ, tissue and bone marrow transplants include coverage for immunosuppressive drugs prescribed for transplant procedures.

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

   a. Solid Human Organ Transplants of the:

      a. Liver;

      b. Heart;

      c. Lung;

      d. Kidney;

      e. Pancreas;

      f. Small Bowel; and

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

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

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

      The following tissue transplants are covered:

a. Blood transfusions;

b. Autologous parathyroid transplants;

c. Corneal transplants;

d. Bone and cartilage grafting;

e. Skin grafting;

f. Autologous islet cell transplants; and

g. 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

a. Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.

b. 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 13. PREGNANCY CARE

The following Pregnancy Care Benefits are available to You when coverage is in effect when such services are furnished in connection with Your pregnancy:

A. Medical and Surgical Services

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

2. Diagnostic Services.

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

4. Medically Necessary abortions required to save the life of the mother.

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

B. Facility Services

Pregnancy Care Benefits for Hospital services required in connection with pregnancy and Medically Necessary abortions (as described above) are subject to the Pregnancy Care Deductible Amount and Coinsurance or Copayment, shown on the Schedule of Benefits.

An Authorization is required for a Hospital stay in connection with childbirth for the covered mother only if the mother's length of stay is longer than 48 hours after a vaginal delivery or 96 hours after a cesarean section.

There is no coverage for newborns under this Policy.

Elective deliveries before the thirty-ninth (39th) week of gestation are not covered unless shown to be Medically Necessary. Facility and other charges associated with an elective early delivery that is not Medically Necessary are also considered to be non-covered.

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

C. Benefits

1. **Network Benefits**: If shown on the Schedule of Benefits, a Pregnancy Care Deductible Amount will apply to Covered Services rendered by Network Providers, for each covered pregnancy. A Network Deductible Amount and Coinsurance may apply to some plans, if shown on the Schedule of Benefits.

2. **Non-Network Benefits:** If shown on the Schedule of Benefits, a Pregnancy Care Deductible Amount will apply to Covered Services rendered by Network Providers, for each covered pregnancy. A Non-Network Deductible Amount and Coinsurance may apply to some plans, if shown on the Schedule of Benefits.

3. You must pay the Inpatient Hospital Admission Coinsurance and Pregnancy Care Coinsurance, in addition to the Pregnancy Care Deductible Amount. A Non-Network Deductible Amount and Coinsurance may apply to some plans, if shown on the Schedule of Benefits.

ARTICLE 14. REHABILITATIVE AND HABILITATIVE CARE BENEFITS

If shown on the Schedule of Benefits, limitations may apply to the following Benefits.

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

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

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

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his or her license, including a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.

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

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

B. Physical Therapy

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

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

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

   a. to children with a diagnosed developmental disability according to Your plan of care;

   b. as part of a Home Health Care agency according to Your plan of care;

   c. to a patient in a nursing home according to Your plan of care;

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

   e. to someone for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider giving the diagnosis. The diagnosis must have been made within the previous ninety (90) days. The physical therapist must provide the healthcare Provider who gave the diagnosis with a plan of care for Physical Therapy services within the first 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 or her license, including a speech pathologist or by an audiologist.

2. The therapy must be used to improve or restore speech/language deficits, speech/language development disorders, cognitive communication, or swallowing function.

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

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his or her 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 15. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following Benefits are available to You, subject to other limitations shown on the Schedule of Benefits.

A. Ambulance Service Benefits

1. Ground Ambulance Transport Services

   a. Emergency Transport

   Benefits for Ambulance Services are available for local transportation for Emergency Medical Conditions or Medically Necessary Inpatient Hospital services only for You, to or from the nearest Hospital capable of providing services appropriate to Your condition for an illness or injury requiring Hospital care.

   b. Non-Emergency Transport

   Benefits for Ambulance Services are available for local transportation of Members for non-Emergency medical conditions to obtain Medically Necessary Inpatient or Outpatient services when the Member is bed-confined or the Member's condition does not allow the use of any other method of transportation. The term bed-confined is not synonymous with bed rest or non-ambulatory. Benefits for non-Emergency transport are only available for transport to or from the nearest facility or Hospital capable of providing the Medically Necessary services.

   To be considered bed-confined and to qualify for non-Emergency transport, the Member must be unable to do all of the following:

   a. get up from bed without assistance;

   b. walk or move about freely; and

   c. sit in a chair or wheelchair.

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

2. Ground Ambulance Without Transport

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

3. Air Ambulance Transport Services

   a. Emergency Transport

      Your Policy covers air Ambulance Services for an Emergency Medical Condition. For Emergency Medical Conditions, onsite police or medical authorities must request the air Ambulance Services for Your Policy to cover them.

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

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

   b. Non-Emergency Transport

      If Authorized by Us before services are rendered, Benefits for non-Emergency air Ambulance Services are available for You, to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care. Once Authorized, You should verify that the air Ambulance Service Provider is in Network in the state or area based on the ZIP code where You are picked up. To find a Network Provider in the state or area, go to the Blue National Doctor & Hospital Finder at **http://provider.bcbs.com** or call 1-800-810-2583.

4. Ambulance Service Benefits will be provided as follows:

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

   b. The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.

   c. No Benefits are available if transportation is provided for Your comfort or convenience.

   d. No Benefits are available when a Hospital transports You between parts of its own campus or between facilities owned or affiliated with the same entity.

B. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder is covered when rendered or prescribed by a Physician or Allied Health Professional. You must pay the Copayment, Deductible Amount, and Coinsurance that apply to the type of Provider rendering services for this condition.

C. Autism Spectrum Disorders

Autism Spectrum Disorder Benefits include, but are not limited to, the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Rehabilitative and Habilitative Care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Members who have not yet reached their twenty-first (21st) birthday are eligible for Applied Behavior Analysis, when We determine it is Medically Necessary. Applied Behavior Analysis is not covered for Members age twenty-one (21) and older.

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

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

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

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

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, including, but not limited to, contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, Surgical adjustments of the non-mastectomized breast, unforeseen medical Complications which may require additional reconstruction in the future;

    c. Prostheses; and

    d. Treatment of physical Complications of all stages of the mastectomy, including lymphedemas.

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

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

    a. were previously diagnosed with breast cancer;

    b. completed treatment for breast cancer;

    c. underwent bilateral mastectomy; and

    d. were subsequently determined to be clear of cancer.

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

E. Cleft Lip and Cleft Palate Services

Covered services include the following:

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

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

3. Orthodontic treatment and management;

4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy. The preventive and restorative dentistry services must not be more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies and must be as likely to produce equivalent therapeutic or diagnostic results for diagnosing or treating the patient's condition, or the services will not be covered;

5. Speech/Language evaluation and therapy;

6. Audiological assessments and amplification devices;

7. Otolaryngology treatment and management;

8. Psychological assessment and counseling; and

9. Genetic assessment and counseling for the patient and parents.

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

F. Clinical Trial Participation

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

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

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

   b. And either,

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

      b. You provide medical and scientific information establishing that Your participation in such trial would be appropriate based upon You meeting the conditions described in paragraph a, above.

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

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

    a. The National Institutes of Health.

    b. The Centers for Disease Control and Prevention.

    c. The Agency for Health Care Research and Quality.

    d. The Centers for Medicare & Medicaid Services.

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

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

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

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

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

    a. The Department of Veterans Affairs.

    b. The Department of Defense.

    c. The Department of Energy.

7. The following services are not covered:

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

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

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

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

8. Treatments and associated protocol-related patient care not excluded in this paragraph will be covered if all of the following criteria are met:

    a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other Life-Threatening Illness or for the prevention or early detection of such diseases.

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

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

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

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

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

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

G. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

   a. Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by Your treating Provider.

   b. Evaluation and training programs for diabetes self-management are covered subject to the following:

      a. The program must be prescribed by Member's treating Provider and provided by a licensed healthcare professional who certifies that You have successfully completed the training program.

      b. The program will comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

2. Diabetic Retinal Screening

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

H. Dietitian Visits for Nutritional Counseling

Benefits are available for Outpatient visits to registered dietitians for nutritional counseling. One (1) dietitian visit for nutritional counseling is covered at no cost to Members when the dietitian is a Network Provider. All other subsequent dietitian visits for nutritional counseling are covered at standard Benefits. Dietitian visits for diabetics are available under a separate Benefit for diabetes education and training for self-management.

I. Disposable Medical Equipment and Supplies

Disposable medical equipment and supplies, which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by Us. The equipment and supplies are subject to Your medical Deductible Amount and Coinsurance.

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

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

1. Durable Medical Equipment

   a. Your Policy covers Durable Medical Equipment when the equipment is prescribed by a Physician and Authorized by Us before You obtain it. The equipment must not be provided mainly for comfort or convenience. Also, the equipment must meet all of the following criteria:

      (1) It must withstand repeated use;

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

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

      (4) It is appropriate for use in Your home.

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

      (1) Benefits for the rental of Durable Medical Equipment will be based on the rental Allowable Charge (but not more than the purchase Allowable Charge).

      (2) At Our option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use. The purchase of Durable Medical Equipment will be based on the purchase Allowable Charge.

      (3) When Durable Medical Equipment is approved by Us, Benefits for standard equipment will be provided toward any deluxe equipment.

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

      (a) that do not serve a medical purpose;

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

      (c) that are solely for the Member's comfort or convenience; or

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

      (4) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.

(5) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement due to loss, theft, misuse, abuse, neglect, or destruction is not covered. We also will not cover replacement in cases where the Member sells or gives away the equipment. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Policy, will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment subject to a recall within five (5) years after purchase or rental will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

c. Limitations for Durable Medical Equipment.

a. There is no coverage during rental of Durable Medical Equipment for repair adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.

b. There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.

c. There is no coverage for repair or replacement of equipment due to loss, theft, misuse, abuse, neglect, or destruction. There is no coverage for replacement of equipment in cases where the Member sells or gives away the equipment.

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

e. Regardless of claim of Medical Necessity, deluxe equipment or deluxe features and functionalities of equipment that are not approved by Us are not covered.

2. Orthotic Devices

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

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

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

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

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

(a) that do not serve a medical purpose;

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

(c) that are solely for the Member's comfort or convenience; or

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

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

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

3. Prosthetic Appliances and Devices (Non-Limb)

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

a. There is no coverage for fitting or adjustments, as these are included in the Allowable Charge for the Prosthetic Appliance or Device.

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

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

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 the Member's comfort or convenience; or

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

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

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

Your Policy will pay to buy Prosthetic Appliances and Devices and Prosthetic Services of the limbs that We Authorize, and are covered subject to the following:

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

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

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

(a) that do not serve a medical purpose;

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

(c) that are solely for the Member's comfort or convenience; or

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

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

c. You may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Policy and may pay the difference between the price of the appliance or device and the Benefit payable, without financial or contractual penalty to the Provider of the appliance or device.

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

K. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services only:

1. WHEN WRITTEN AUTHORIZATION OF MEDICAL NECESSITY IS GIVEN BY THE COMPANY PRIOR TO SERVICES BEING PERFORMED; AND

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

L. Hearing Benefits

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

2. Benefits are available for Medically Necessary 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.

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

M. High-Tech Imaging Services

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.

N. Home Health Care

Home Health Care services provided to You instead of an Inpatient Hospital Admission are covered, subject to the Benefit Period limitations shown on the Schedule of Benefits.

O. Hospice Care

Hospice Care is covered, subject to the Benefit Period limitations shown on the Schedule of Benefits.

P. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter or transliterator are covered when You need such services in connection with medical treatment or diagnostic Consultations performed by a Physician or Allied Health Professional, if the services are required because of hearing loss or Your failure to understand or otherwise communicate in spoken language. These services are not covered if rendered by a family member, or if the medical treatment or diagnostic consultation is not covered.

Q. Low Protein Food Products for Treating Inherited Metabolic Diseases

Low-Protein Food Products for treating certain Inherited Metabolic Diseases are covered. Inherited Metabolic Diseases are diseases caused by an inherited abnormality of body chemistry. Low-Protein Food Products are foods that are especially formulated to have less than one (1) gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low-Protein Food Products do not include natural foods that are naturally low in protein.

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

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

R. Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed Physician or received in a Hospital or other public or private facility Authorized to provide lymphedema treatment. Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

S. Permanent Sterilization Procedures

1. Tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes are covered as a Preventive or Wellness Care Benefit at no cost to Members when Covered Services are provided by a Network Provider.

2. Vasectomy is covered and subject to standard Benefits. A vasectomy is not a Preventive or Wellness Care Benefit.

T. Prescription Drugs

Prescription Drugs approved for self-administration (for example, oral and self-injectable drugs) must be obtained through the Prescription Drug Benefits section of this Policy.

U. Private Duty Nursing Services

1. Private Duty Nursing Services are subject to the Deductible Amount and Coinsurance shown on the Schedule of Benefits.

2. Coverage is available to You for Private Duty Nursing Services, when performed on an Outpatient basis and when the RN or LPN is not related to You by blood, marriage or adoption.

3. Private Duty Nursing Services are subject to the Benefit Period maximums shown on the Schedule of Benefits.

4. Inpatient Private Duty Nursing Services are not covered.

V. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage.

W. Telehealth Services and Remote Patient Therapy Services

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

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

Store Forward or Asynchronous Telehealth Services between an established patient and their Provider may take place when an established patient sends pre-recorded video or images to a Provider via HIPAA-compliant communication at the Provider's request, or when the data is transferred between two Providers on the patient's behalf. This method of Telehealth Services is limited to services approved by Us.

Store Forward or Asynchronous Remote Patient Therapy Services between an established patient and a Provider who has an established, documented, and ongoing relationship with the patient may take place when

an established patient uses an FDA-approved or FDA-authorized device to collect and electronically transmit biometric data to a Provider to be analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. This method of Remote Patient Therapy Services is limited to services and devices approved by Us.

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

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

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

In general, there is no coverage for Telehealth Services or Remote Patient Therapy Services that are not within the scope of the Provider's license or fail to meet any standard of care compared to an in-person visit. Coverage does not exist for non-HIPPA compliant encounters which do not provide a system of secure communication to safeguard protected health information.

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

ARTICLE 16. CARE MANAGEMENT

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

For a list of items and services that require Authorization, visit the website, **www.bcbsla.com/priorauth.**

1. Authorization and Selection of Provider

   Benefits will be paid at the highest Network level when care is received from a Network Provider. Participating and Non-Participating Providers are Non-Network Providers.

   a. If a Member wants to receive services from a Non-Network Provider and obtain the 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 seventy-five (75) mile radius of the Member's home. The Non-Network Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Non-Network Provider.

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

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

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

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

   If a required Authorization is not requested before Admission or receiving other Covered Services and supplies requiring an Authorization, We have the right to determine if the Admission or other Covered Services and supplies were Medically Necessary.

   If the Admission or other Covered Services were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and You must pay all charges incurred.

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

a. Admissions

   a. If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. The Network Provider or Participating Provider is responsible for all charges not covered. The Member remains responsible for any applicable Copayment, Deductible Amount, and Coinsurance shown on the Schedule of Benefits.

   b. 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. The Member is responsible for all charges not covered and for any applicable penalty, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

b. Outpatient Services, Including Other Covered Services and Supplies

   a. If a Network Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by the penalty stipulated in the Provider's contract. This penalty applies to all Outpatient services and supplies requiring an Authorization. The Network Provider is responsible for all charges not covered. The Member remains responsible for any applicable Copayment, Deductible Amount, and Coinsurance.

   b. If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on the Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for any Deductible Amount and Coinsurance shown on the Schedule of Benefits.

   c. If a service or supply was not Medically Necessary, the service or supply is not covered.

   d. If a Provider fails to obtain a required Authorization for the Outpatient services and supplies which indicate no Benefit without written / prior Authorization on the prior Authorization list, the Outpatient services and supplies are not covered.

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 or facility. 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.

      a. If a request for Authorization is denied, the Admission is not covered and You must pay all charges incurred during the Admission for which Authorization was denied.

b. If Authorization is not requested before an Admission, We 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.

c. Additional amounts for which You are responsible because Authorization of an Elective or non-Emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not accrue to the Deductible Amount or 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 Provider or facility. We may waive or extend this time limitation if We determine that the Member is unable to timely notify or direct a 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.

a. If Authorization is denied, the Admission will not be covered and the Member must pay all charges incurred during the Admission.

b. If Authorization is not requested, We 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.

c. 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 accrue to the Deductible Amount or 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 or facility.

a. If We do not receive a request for Authorization for continued stay on or before Your 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 the Providers, in writing, that the request is denied and no additional days are Authorized.

b. If We deny a Concurrent Review request or level of care request for Hospital Services, We will notify the Member, the 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 the Member is notified of the financial responsibility by the Physician or Hospital before incurring additional charges.

c. Charges for non-Authorized days in the Hospital that the Member must pay are considered non-covered and will not accrue to the Deductible Amount or 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 prior Authorizations before the 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 or facility.

   a. If a request for Authorization is denied by Us, the Outpatient services and supplies are not covered.

   b. If a Provider fails to obtain Authorization for the Outpatient services and supplies which indicate no Benefit without written / prior Authorization on the prior Authorization list, the Outpatient services and supplies are not covered.

   c. If Authorization is not requested before receiving Outpatient services and supplies requiring Authorization, We have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider.

   d. 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 Deductible Amount or Out-of-Pocket Amount.

B. Disease Management

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

2. Disease Management – HMO Louisiana, Inc.'s disease management programs are committed to improving the quality of care for You as well as decreasing healthcare costs in populations with a chronic disease. The nurse works with You to help You learn the self-care techniques You will need to manage Your chronic disease, establish realistic goals for lifestyle modification, and improve adherence to Your Physician's

prescribed treatment plan. HMO Louisiana, Inc. is dedicated to supporting the Physician's efforts in improving Your health status and well-being.

C. Case Management

1. You may qualify for Case Management services, at Our discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with You, Your Physicians and families, and other community resources to assess treatment alternatives and available Benefits.

2. The role of Case Management is to service You by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who Benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.

3. Our determination that Your particular medical condition renders You a suitable candidate for Case Management services will not obligate Us to make the same or similar determination for any other covered person. The provision of Case Management services to one Member will not entitle any other Member to Case Management services or be construed as a waiver of Our right to administer and enforce this Policy according to its express terms.

4. Unless We expressly agree, all terms and conditions of this Policy, including maximum Benefit limitations and all other limitations and exclusions, will be and remain in full force and effect for You when receiving Case Management services.

5. Your Case Management services will be terminated upon any of the following occurrences:

   a. We determine in Our sole discretion, that You are no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.

   b. The short and long-term goals established in the Case Management plan have been achieved, or You elect not to participate in the Case Management plan.

D. Alternative Benefits

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

2. Our determination that a particular Your medical condition renders You a suitable candidate for Alternative Benefits will not obligate Us to make the same or similar determination again; nor will the provision of Alternative Benefits be construed as a waiver of Our right to administer and enforce this Policy according to its express terms.

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

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

5. Your Alternative Benefits will be terminated upon any of the following occurrences:

   a. We determine, in Our sole discretion, that You are no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.

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

ARTICLE 17. LIMITATIONS AND EXCLUSIONS

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

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

If a member has Complications from excluded conditions, surgery, or treatments benefits for such conditions, services, surgery, supplies and treatment are excluded.

B. We May Delete or Revise Limitations or Exclusions in this Policy

ANY LIMITATION OR EXCLUSION LISTED IN THIS POLICY MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.

C. Additional Limitations and Exclusions

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 policy. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.

2. Any charges more than the Allowable Charge.

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

4. Benefits are excluded for services, surgery, supplies, treatment, or expenses:

   a. other than those specifically listed as covered by this Policy or for which You have no obligation to pay, or for which no charge or a lesser charge would be made if You 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 Your Effective Date or after Your 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 Your coverage under this Policy ends, until the end of that Admission or until You have reached any Benefit limitations set in this Policy, 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 their license;

d. to the extent payment has been made or is available under any other contract issued by HMO Louisiana, Inc. or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited Benefit policies;

e. which are Investigational in nature, except as specifically provided in this Policy. Investigational determinations are made according to Our policies and procedures;

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

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

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

i. for telephone calls, video communication, text messaging, e-mail messaging, instant messaging or patient portal communications between You and Your Provider unless specifically stated as covered under the Telehealth Services Benefit; for services billed with Telehealth codes not suitable for the setting in which the services are provided; for Telehealth Services not permitted by Us; and for Telehealth Services rendered by Providers not permitted by Us.

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

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

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

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

n. for paternity tests and tests performed for legal purposes.

5. Benefits are excluded for services in the following categories:

   a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war;

b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;

c. those occurring as a result of taking part in a riot or acts of civil disobedience;

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

e. those occurring as a result of Your 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 You for illness or bodily injury otherwise covered under this Contract when the illness or bodily injury arises out of an act of domestic violence or a medical condition (including both physical and Mental Health conditions); or in case of Emergency Medical Services, the initial medical screening examination, treatment and stabilization of an Emergency Medical Condition.

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 Policy;

   e. implantation, removal or re-implantation of breast implants and services, illnesses, conditions, Complications or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Policy. When a Medically Necessary mastectomy is otherwise covered under this Policy, removal of breast implants that were originally implanted during a Cosmetic Surgery and/or for cosmetic purposes is only covered when removal constitutes an incidental service under the Medical and Surgical Benefits Article of this Policy. As an incidental service, the removal of breast implants, capsulectomy, and other services, treatments, or procedures determined by Us to be an incidental service may not be billed separately;

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

   g. diastasis recti;

   h. biofeedback;

   i. lifestyle/habit changing clinics and/or programs, except those We offer, endorse, approve, or promote as part of Your healthcare coverage under this Benefit Plan. Some of these programs may be offered as value-added services and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs.

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

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

l. industrial testing or self-help programs including stress-management programs, work-hardening programs or functional-capacity evaluations; driving evaluations, etc.;

m. recreational therapy, including, but not limited to, providing treatment, services and recreation activities using a variety of techniques including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings;

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

o. primarily to enhance athletic abilities.

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

   a. routine eye exams (except for those for diabetics shown in the Benefits section), eyeglasses or contact lenses (except for the initial pair and fitting of eyeglasses or contact lenses required after cataract Surgery), unless shown as covered in this policy or on the Schedule of Benefits;

   b. eye exercises, visual training, or orthoptics;

   c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Policy;

   d. hair pieces, wigs, hair growth, or hair implants;

   e. the correction of refractive errors of the eye, including 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 You are a donor except as provided in this Policy;

   b. transplant procedures for any human organ or tissue transplant not specifically listed as covered.

   c. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;

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

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

9. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for 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.

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

    a. weight reduction programs;

    b. bariatric surgery procedures including, but not limited to:

        a. Roux-en-Y gastric bypass

        b. Laparoscopic adjustable gastric banding

        c. Sleeve gastrectomy

        d. 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.

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

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

    a. lifestyle-enhancing drugs including, but not limited to, medications used for cosmetic purposes (for example, 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 (for example, Propecia®, Rogaine®), e except for Prescription Drugs approved by Us to treat alopecia areata or alopecia universalis;

    b. medications for obesity, weight loss, weight management, or weight maintenance (e.g., Contrave®, Qsymia®, Saxenda®, Wegovy™);

    c. any medication not proven effective in general medical practice;

    d. Investigational drugs and drugs used other than for the FDA approved indication along with all Medically Necessary services associated with the administration of the drug, except drugs that are not FDA approved for a particular indication but that are recognized for treating the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two (2) peer reviewed national professional medical journals or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by Us;

    e. fertility drugs;

f. nutritional or dietary supplements, or herbal supplements and treatments;

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;

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. IUDs and implantable contraceptive devices that do not result in permanent sterilization;

l. refills that are more than the number specified by the Physician or the dispensing limitation described in this Policy, or a refill before 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:

    a. are similar to a commercially available product;

    b. whose principal ingredients are being used for an indication for which no FDA approval exists;

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

    d. 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

    e. 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 are excluded;

q. Prescription Drug compounding kits are excluded;

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 before Yours Effective Date or after Your 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 (for example, Viagra®, Cialis®, Levitra®), low sexual desire disorder (Addyi®) or other sexual inadequacies;

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

z. Prescription Drugs for and 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 requiring future Controlled Dangerous Substances to be obtained from only one (1) prescriber and one (1) 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 used or the drug was not approved by Us or Our Pharmacy Benefit Manager;

dd. 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;

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

ff. 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 Your Coinsurance and Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than Your Copayment, in which case, You must pay the Prescription Drug cost and sales tax.

13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for personal comfort, personal hygiene and convenience items including air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to Your home or vehicle.

14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for routine foot care; palliative or cosmetic care or treatment of the foot; 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 people 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 other than to save the life of the mother.

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

17. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, supplies or treatment related to artificial means of Pregnancy including in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.

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

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

    a. genetic testing, unless the results are specifically required for a medical treatment decision or if required by law;

    b. pre-implantation genetic diagnosis;

    c. preconception carrier screening; and

    d. prenatal carrier screening except screenings for cystic fibrosis.

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

21. **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.

22. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Policy under Oral Surgery Benefits and Cleft Lip and Cleft Palate Services.

23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for dental implants except as specifically provided in this Policy under Oral Surgery Benefits and Cleft Lip and Cleft Palate Services.

24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular Joint (TMJ) Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition. This exclusion does not apply to Cleft Lip and Cleft Palate Services.

25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Medical exams 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 Policy.

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

27. **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.

28. **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 other learning disabilities. This includes Applied Behavior Analysis (ABA) services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes.

29. Benefits are excluded for Applied Behavior Analysis that We determine is not Medically Necessary. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** the following are also excluded: ABA rendered to Members age twenty-one (21) and older; ABA rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

30. **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, for example, Outpatient department of a Hospital or Physician's office.

31. **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. This exclusion for Custodial Care does not apply to Habilitative Care services. This exclusion for Custodial Care applies to Claims for Private Duty Nursing Services that are determined by Us to be Custodial Care.

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

33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, parental counseling and employment counseling.

34. **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).

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

36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by Us.

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

38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Mental Health services or substance use disorder services delivered through the Psychiatric Collaborative Care Model when used to treat a condition other than an approved behavioral health diagnosis.

39. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Virtual reality services, supplies, technologies, treatment, devices, or expenses related thereto no matter the setting in which virtual reality is used, including, but not limited to, Surgery.

ARTICLE 18. GENERAL PROVISIONS

A. This Policy

1. This Policy, the Application for Short Term Medical Coverage expressing the entire money and other consideration for coverage, the Schedule of Benefits, and any amendments or endorsements make up the entire Policy between the parties.

2. This Policy is subject to underwriting. Not every applicant will be approved for initial or renewed coverage.

3. This Policy is not guaranteed renewable or extendable except at the Company's option and to the extent permitted by applicable law. If You wish to renew or continue coverage of this Policy, the Company will redetermine Your eligibility and notify You if You are accepted for renewal or continued coverage.

4. We reserve the right to enter into any contractual agreements with subcontractors, healthcare providers, or other third parties relative to this Policy. Any function to be performed by Us under this Policy may be performed by Us or any of Our subsidiaries, affiliates, subcontractors, or designees.

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

6. Continuity of healthcare services.

    a. When We end a contractual agreement with a Provider, if You have begun a course of treatment with that Provider, We will notify You that We have removed the Provider from the HMOLA Network. If you

are a continuing care patient, You can continue receiving Covered Services until the earlier of the completion of the course of treatment or ninety (90) days after We notify You that the Provider has left the Network.

b. A continuing care patient is one who is:

   (1) Undergoing a course of treatment for a Serious and Complex Condition.

   (2) Undergoing a course of institutional or Inpatient care.

   (3) Scheduled to undergo non-elective Surgery from the Provider, including receipt of postoperative care;

   (4) Pregnant and undergoing a course of treatment for the pregnancy; or

   (5) Terminally ill, which means the medical prognosis is a life expectancy of six (6) months or less and receiving treatment for the terminal illness from the Provider.

c. The provisions of continuity of care do not apply if any one of the following occurs:

   (1) The reason for termination of a Provider's contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.

   (2) The reason for termination of a Provider's contractual agreement is as a result of fraud.

   (3) You voluntarily choose to change Providers.

   (4) You move outside of the geographic Service Area of the Provider or the Provider Network.

   (5) Your condition does not meet the requirements to be deemed a Serious and Complex Condition.

B. Section 1557 Grievance Procedure

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

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

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

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

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

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

The Section 1557 Coordinator will issue a written decision on the grievance no later than thirty (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 fifteen (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 thirty (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
1-877-696-6775

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

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

C. Policy Changes

Subject to all laws that apply, We reserve the unlimited right to modify the terms of this Policy in any way. Changes will be effective upon renewal of the Policy and preceded by not less than sixty (60) days' notice to You. We will

issue to You an amendment to this Policy specifying the modification of the terms of this Policy as well as the Effective Date of the amendment. No change or waiver of any Policy provision will be effective until approved by Our chief executive officer or a delegate.

D. 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, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with Your care or treatment.

E. Identification Cards

We will issue an ID card to You. You must present the ID card whenever You receive Covered Services. ID cards are not transferable. Unauthorized use of the ID card by anyone can result in termination of Your coverage. The ID card serves only to identify the Member and confers no right to Covered Services or Benefits. To be entitled to Covered Services or Benefits an ID cardholder must be a Member on whose behalf all premiums have actually been paid. You must carry the ID card at all times to ensure prompt receipt of Covered Services. If a card is lost or stolen, notify Us immediately.

F. Due Date for Premium Payments

1. Premiums are due and payable from You in advance, before the coverage being rendered. Premiums are due and payable beginning on the Effective Date of the first Benefit Period of this Policy and on the same date each month thereafter. This is the premium due date. This Policy is renewable on a monthly basis by the timely payment of each premium as it becomes due, until the termination date shown on the termination date shown on the Schedule of Benefits.

2. Premiums are owed by You. Premiums may not be paid by third parties unless related to You by blood or marriage. Premiums may not be paid by Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. We will not accept premium payments by third parties unless required by law to do so. The fact that We may have previously accepted a premium from an unrelated third-party does not mean that We will accept premiums from these parties in the future.

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 US dollars. You will be assessed a twenty-five dollar ($25.00) NSF fee should Your premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, We may at Our sole discretion refuse to reinstate coverage.

G. Change in Premium

1. This Policy will expire on the date shown on Your Schedule of Benefits. The Company has the sole right to decide if this Policy may be renewed or extended to the extent permitted by applicable law. All renewals are subject to Your timely payment of premiums established by the Company for the renewals and extensions.

2. Except as provided in the following paragraph, We will give You forty-five (45) days' written notice of a premium change, at Your last address shown in Our records. Any change in premium will become effective

on the date specified in the notice. If You continue to pay Your premium, You show that You accept the change.

3. Premiums are guaranteed for the Benefit Period. However, We reserve the right to change premiums more often due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Policy. Additionally, We reserve the right to change the premium if You request a change in Benefits from that which was in force at the time of the last rate determination, and We agree to that change.

4. If Your age was misstated, any amount payable or any indemnity accruing under this Policy will be such as the premium paid would have purchased at the correct age. A clerical error will not void insurance which should be in force nor will it continue insurance which should have ended.

5. If non-tobacco premiums are charged when tobacco premiums should have been charged, We may retroactively adjust the premium and collect the appropriate premium.

H. Our Right to Offer Premium Incentives

We may, at Our discretion, offer rebates, refunds, reductions of premium, or other items of value, in amounts or types determined by Us, for business purposes and healthcare quality and improvement purposes, including, but not limited to, the following purposes:

1. Encouraging Members to participate in quality programs;

2. Ensuring Members are better able to afford benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members who have changed insurers;

5. Rewarding Members for choosing lower cost, quality healthcare Providers;

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

7. Rewarding Members for utilizing digital and other paperless forms of communication of information, including, but not limited to, plan documents and materials; and

8. Reducing enrollment, technology, or administration costs of Members, when such costs are related to effectuating and/or maintaining coverage.

I. Your Right to Cancel this Policy

1. You may cancel this Policy by giving written notice to Us at least fourteen (14) days before the date of cancellation.

2. If You write to Us, send Your notice to Us at the home office:

Individual Membership and Billing
HMO Louisiana, Inc.
Attention: Individual Membership and Billing
P. O. Box 98024
Baton Rouge, LA 70898-9024

3. **You may not verbally cancel this Policy. Return this Policy with Your written notice of cancellation**. If You do not include Your Policy when You write to Us to cancel, we will deem Your cancellation notice to Us to include Your declaration that You made a good faith attempt to find Your policy and the policy is not being returned because it was lost or destroyed.

4. If You give Us a cancellation notice, the Policy will be canceled effective on the date that is fourteen (14) days from the date of Your cancellation notice or any later date You request in a written notice to Us, or on a date required by law.

5. If You cancel this Policy, no prepaid premiums will be refunded.

J. Our Right to Terminate this Policy for Nonpayment of Premium

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

2. You have a thirty (30) day grace period (delinquency period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect according to the provisions of the Policy. If We do not receive the premium due during the grace period, We will mail a delinquency or lapse notice to Your address of record. We may also mail a termination notice to Your address of record, We may automatically terminate the Policy without further notice to You if We do not receive Your premium at Our home office within thirty (30) days of the due date (during the grace period). If We terminate this Policy for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. We will not be liable to pay Benefits for services rendered after the last date through which premiums have been paid. We will be under no obligation to re-issue coverage to You during the Benefit Period or thereafter.

3. If this coverage is terminated for non-payment of premium or other amounts, We may require payment of all past due amounts before agreeing to reinstate this coverage or accepting You for coverage on a future Policy of insurance.

4. You agree to pay reasonable costs and fees to Us, including reasonable attorney's fees, for Our attempt to collect any amounts owed under this Policy, including, but not limited to, unpaid premium.

K. Our Right to Rescind Coverage, Terminate or Non-Renew the Policy for Reasons Other Than Nonpayment of Premium

1. If You become covered on another Policy of comprehensive or short term medical coverage by the Company, Our parent, affiliates or subsidiaries, We have the right to cancel this short term medical Policy.

2. If You are already covered on a policy of comprehensive or short term medical coverage with the Company, Our parent, affiliates or subsidiaries, and You purchase this Policy, we will cancel the other coverage as we infer it is Your intent to have only this Policy.

3. Causes for Rescission (retroactive termination) of this Policy:

   You commit fraud or intentionally misrepresents material fact under the terms of this Policy. The issuance of this Policy depends on representations and statements on Your application, during underwriting, or on the Application for Short Term Medical Coverage. All representations made on it are material to the issuance of this Policy. Any information intentionally omitted from the application about You will be an intentional misrepresentation of material fact. In such event, We will give You thirty (30) days' advance written notice by

certified mail and will include the reason for Rescission. Rescission could be retroactive to the Effective Date of coverage.

4. Causes for termination of coverage or non-renewal of this Policy:

   a. The Company determines You are no longer eligible for coverage; the Company decides not to renew or extend Your coverage; the maximum period of coverage on this short term medical Policy has been reached; or other reasons determined by the Company in its sole discretion. This Policy is not guaranteed renewable or extendable.

   b. You fail to comply with a material plan provision or obligation under this Policy. In such event, We will give You sixty (60) days' advance written notice by mail and will include the reason for termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

   c. You no longer live or reside in the Service Area where We are authorized to do business. In such event, We will give You 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.

   d. We cease to offer this product or coverage in the market. In such event, We will give You written notice by regular mail ninety (90) days before the termination or non-renewal. The effective date of the termination or non-renewal will be provided in the notice.

   e. You enroll in another Policy of medical coverage with Us or another company. In such event, coverage will be terminated effective on the day before coverage in the other coverage begins, or when the Company determines other coverage is in effect.

L. Termination of Your Coverage

1. All coverage will end at the end of the period for which premiums have been paid. Prepayment of premiums does not mean the Company will renew or extend coverage beyond the Termination of Coverage date shown on the Schedule of Benefits. No Benefits are available for Covered Services rendered after the date of termination of coverage. However, if You are an Inpatient in a Hospital on the date of termination, medical Benefits in connection with the Admission will terminate at the end of that Admission or upon reaching any Benefit limitations set in this Policy, whichever occurs first.

2. If You move outside Our Service Area with the intent to move or establish a new residence outside Our Service Area, Your coverage will be terminated.

M. Filing of Claims

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

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

N. Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.

2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

3. Any legal action filed against the Policy must be filed in the appropriate court in the State of Louisiana.

O. Release of Information

We may request that You or Your Provider furnish certain information relating to Your 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 Policy; You may not assign them in whole or in part to someone else. We will recognize assignments of Benefits to Hospitals if both this Policy and the Provider are subject to La. R.S. 40:2010. If both this Policy and the Provider are not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of Benefits. Nothing in the written description of health coverage will be construed to make the health plan or Us liable to any third-party to whom You may be liable for the cost of medical care, treatment, or services.

2. We reserve the right to pay HMOLA Network Providers, and Providers in the Blue Cross and Blue Shield of Louisiana Participating Provider Network directly instead of paying You.

Q. Member and Provider Relationship

1. The choice of a Provider is Yours only.

2. We and all Network Providers are to each other independent contractors, and will not be considered agents, representatives, or employees of each other for any purpose whatsoever. HMO Louisiana, Inc. does not render Covered Services but only makes payment for Covered Services You receive. We are not liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any Network Provider or in any Network Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to You.

3. Use or non-use of an adjective such as Network or Non-Network referring to a Provider is not a statement about the ability of the Provider.

R. Applicable Law and Conforming Policy

This Policy will be governed and construed according to the laws and regulations of the State of Louisiana except when preempted by federal law. This Policy is not subject to regulation by any state other than the State of Louisiana. This Policy does not and is not required to conform to the Patient Protection and Affordable Healthcare Act or its essential health benefits package and requirements. If any provision of this Policy conflicts with any law of the State of Louisiana or the United States of America that applies to it, the Policy will be automatically amended to meet the minimum requirements of the law.

S. Notice

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

T. Doing Business with You Electronically

The Company is moving more operations to electronic means. If You have opted in to do business with Us electronically, electronic means takes precedence over other forms of notice or communication described in this Policy, when it is within the Company's ability to perform electronically.

U. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Policy, We will be subrogated and will succeed to Your right for the recovery of the amount paid under this Policy against any person, organization, insurer or other carrier even where such insurer or carrier provides Benefits directly to You who are its insured. The acceptance of such Benefits under this Policy will constitute subrogation. Our right to recover will be contingent on Your right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or a judgment following a trial. We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.

2. You will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization, insurer or other carrier, even where such carrier provides Benefits directly to You who is its insured, to the extent of the Benefits provided or paid under this Policy. Our right to recover will be contingent on Your right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or judgment following a trial. We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.

3. You will take such action, furnish such information and assistance, and execute such papers as We may be required to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interests under this Policy. We and Our designees have the right to obtain and review Your medical and billing records if We determine, in Our sole discretion, that such records would be helpful in pursuing Our right of subrogation and reimbursement.

4. You must notify Us of any Accidental Injury.

V. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that is more than the maximum Benefits available for such services under this Policy or is more than the Allowable Charge, or whenever payment has been made in error by Us for non-Covered Services, We will have the right to recover such payment from You or, if it applies, the Provider. As an alternative, We reserve the right to deduct from any pending Claim for payment under this Policy any amounts that We are owed by You or the Provider.

W. 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 or her own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

X. Liability of Plan Affiliates

You expressly acknowledge Your understanding that this agreement is a Policy only between You and HMO Louisiana, Inc., that HMO Louisiana, Inc. is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the Association) permitting HMO Louisiana, Inc. to use the Blue Cross and Blue Shield service marks in the State of Louisiana, and that HMO Louisiana, Inc. is not contracting as the agent of the Association. You also acknowledge and agree that You have not entered into this Policy based on representations by anyone other than HMO Louisiana, Inc. and that no person, entity, or organization other than HMO Louisiana, Inc. will be held accountable or liable to You for any of HMO Louisiana, Inc.'s obligations to You created under this Policy. This paragraph does not create any additional obligations on the part of HMO Louisiana, Inc. other than those obligations created under other provisions of this Policy.

Y. Out-of-Area Services

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

When You receive care outside Our Service Area and the Service Area of Blue Cross and Blue Shield of Louisiana, You will receive care 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.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

1. BlueCard® Program

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

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

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

When You receive Covered Services outside Our Service Area and the Claim is processed through the BlueCard® Program, the amount You pay for the 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 overestimation or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price We used for Your Claim because We will not apply them after a Claim has already been paid.

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

2. Non-Participating Providers Outside Our Service Area

a. Member Liability Calculation

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

b. Exceptions

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

3. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter BlueCard® Service Area), You may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists You with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard® Service Area, You will typically have to pay the Providers and submit the Claims Yourself to obtain reimbursement for these services.

For medical assistance services (including locating a doctor or Hospital) outside the BlueCard® Service Area, call:

Blue Cross Blue Shield Global® Core service center
24 hours a day, 7 days a week
1-800-810-BLUE (2583),

or call collect:

1-804-673-1177

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, and the Provider agrees to accept a guaranteed payment, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible Amount and Coinsurance. The Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center. However, if the Provider does not agree to a guaranteed payment or You otherwise 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 and meet other requirements in your Policy for services to be provided, including, but not limited to, receiving only Medically Necessary services .

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. Exceptions

In situations where the Blue Cross Blue Shield Global® Core service center is unable to obtain a guaranteed payment for a Global® Core claim, We may use other payment methods to figure the

payment We will make for the health care services that were delivered outside Our Service Area. Those other payment methods include, but are not limited to, billed charges for Covered Services, the payment We would make if the health care services had been obtained within Our Service Area, or a special negotiated payment to determine the amount We will pay for services from Non-Participating Providers. In these situations, You need to comply with the requirements of your Policy and You may have to pay the difference between the amount that the Provider bills and the payment We will make for the Covered Services.

d. 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. 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.

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**.

For assistance with Your Claim submission, call:

Blue Cross Blue Shield Global® Core service center
24 hours a day, 7 days a week
1-800-810-BLUE (2583),

or call collect:

1-804-673-1177.

ARTICLE 19. COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

We want to know when You are dissatisfied about the care or services You receive from HMO Louisiana, Inc. or one of Our Providers. If You want to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

You may be dissatisfied about decisions We make regarding Covered Services. We consider a written Appeal as Your request to change an Adverse Benefit Determination made by the Company.

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

We have expedited Appeals processes for situations where the time frame of the standard Medical Appeals would seriously jeopardize Your life or health or would jeopardize Your 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 You.

1. To Register a Complaint

   A Complaint is an oral expression of dissatisfaction with Us or with Provider services. You may call customer service to register a Complaint. We will attempt to resolve Your Complaint at the time of Your 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 You do not feel Your Complaint was adequately resolved or You wish to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, You may call Our customer service department.

   Send written Grievances to the address listed below:

   HMO Louisiana, Inc.
   Appeals/Grievances Department
   PO Box 98045
   Baton Rouge, LA 70898-9045

   A response will be mailed to You within thirty (30) business days of receipt of Your written Grievance.

3. Informal Reconsideration

   An Informal Reconsideration is a request by telephone, made by an authorized Provider on Your behalf, to speak to Our medical director or a peer reviewer about a Utilization Management decision that We have made. An Informal Reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

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

B. Standard Appeal Process

If You are not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination for administrative Appeals and internal medical Appeals. Requests submitted to Us after one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination will not be considered.

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

If you have questions or need assistance, You may call Our customer service department.

You have the right to appoint an authorized representative to speak on Your behalf in Your Appeals. An authorized representative is a person to whom You have given written consent to represent You in an internal or

external review of an Adverse Benefit Determination. The authorized representative may be Your treating Provider if You appoint the Provider in writing.

We will determine if Yours Appeal is an administrative Appeal or a medical Appeal.

You are 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 You, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination.

1. Administrative Appeals

   Administrative Appeals involve contractual issues and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or Investigational.

   Administrative Appeals should be submitted in writing to:

   HMO Louisiana, Inc.
   Appeals/Grievances Department
   P.O. Box 98045
   Baton Rouge, LA 70898-9045

   Persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the administrative Appeal. If the administrative Appeal is overturned, We will reprocess Your Claim, if any. If the administrative Appeal is upheld, this decision will be considered final and binding.

   The administrative Appeal decision will be mailed to You, Your authorized representative, or a Provider authorized to act on Your behalf, within thirty (30) days of receipt of Your request; unless it is mutually agreed that an extension of time is warranted.

   Administrative Appeals have only one internal level of review and are not eligible for the External Appeal process with the exception of a Rescission.

2. Medical Appeals

   Medical Appeals involve Adverse Benefit Determinations for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational and any related prospective or retrospective review determination.

   We offer You two (2) standard levels of medical Appeals, including an internal review of the initial Adverse Benefit Determination, then an external review.

   Medical Appeals should be submitted in writing to:

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

   a. Internal Medical Appeals

      A Physician or other healthcare professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any

previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, We will reprocess Your Claim, if any. If the internal medical Appeal is upheld, We will inform You of Your right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

The internal medical Appeal decision will be mailed to You, Your authorized representative, or a Provider authorized to act on Your behalf, within thirty (30) days of receipt of Yours request; unless it is mutually agreed that an extension of time is warranted.

b. External Medical Appeal and Rescissions

For medical Appeals and Rescission, the second level will be handled by an external Independent Review Organization (IRO) that is not affiliated with Us and randomly assigned by the Louisiana Department of Insurance.

You must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If You disagree with the internal medical Appeal decision or Rescission, a written request for an External Appeal must be submitted within four (4) months of receipt of the internal medical Appeal decision or Rescission to:

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

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

The IRO decision will be considered a final and binding decision on both You and Us for purposes of determining coverage under a health Policy. This Appeals process shall constitute Your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

C. Expedited Appeals

The expedited Appeal process is available for review of the Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize Your life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, You 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 service for You while in the Emergency room, 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 Your 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 shall be made available to, and may be initiated by You, Your authorized representative, or a Provider authorized to act on Your behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

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

1. Expedited Internal Medical Appeals

   In these cases, We will make a decision no later than seventy-two (72) hours of our receipt of an Expedited Appeal request that meets the criteria for an internal Expedited Appeal. In any case where the Expedited internal medical Appeal process does not resolve a difference of opinion between Us and You or the Provider acting on Your behalf, 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 Appeal is a request for immediate review, by an Independent Review Organization (IRO). The request may be simultaneously filed with a request for an internal Expedited Appeal, since the Independent Review Organization assigned to conduct the expedited external review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

You may contact the Commissioner of Insurance directly for assistance.

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

ARTICLE 20. MAKING POLICY CHANGES AND FILING CLAIMS

HMO Louisiana, Inc. is continuing to update its online access for You. You may now be able to perform many of the functions described below without contacting Our customer service department. Log on to **www.bcbsla.com** to access to these services.

You can find all of the forms mentioned in this section from one of Our local service offices or from the home office of HMO Louisiana, Inc. To submit documentation to Us, send it to Our home office at:

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

or to

5525 Reitz Avenue
Baton Rouge, LA 70809

If You have any questions about any of the information in this section, You may call Your insurance agent or customer service at the number on the ID card.

A. How to File Insurance Claims for Benefits

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

If You need to file a paper Claim, send it to:

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

The. ID card shows the way Your name appears on Our records. The ID card also lists Your Policy number. This number is the identification to Your membership records and should be provided to Us each time a Claim is filed.

To help in prompt handling of Your Claims, be sure that:

1. an appropriate Claim form is used;
2. the Policy number on the form is the same as the number on the ID card;
3. Your date of birth is listed;
4. all charges are itemized on a statement from the Provider;
5. the itemized statement from the Provider contains the Provider's name, address, and tax ID number and is attached to the Claim form;
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 and treatment rendered (the diagnosis code pointers must be consistent with the Claim form); and
8. the Claim is completed and signed by You.

B. 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 a Participating Pharmacy. However, if You must file a Claim to access Your Prescription Drug Benefit, You must use the Prescription Drug Claim form. The Prescription Drug Claim form, or an attachment acceptable to Us, may require the signature of the dispensing

pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager, whose number is on the ID card.

Benefits will be paid to You based on the Allowable Charge for the Prescription Drug.

C. Other Medical Claims

When You receive other medical services (clinics, Provider offices, etc.) You should ask if the Provider is an HMO Louisiana, Inc. or Participating Provider. If yes, this Provider will file Your Claim with Us. In some situations, the Provider may request payment and ask You to file. If this occurs, be sure the claim form is complete before forwarding to HMO Louisiana, Inc. If You are filing the Claim, the Claim must contain the itemized charges for each procedure or service. Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills.

Important Note: Itemized bills submitted with claim forms must include the following:

1. full name of patient;
2. dates of service;
3. description of and procedure code for service;
4. diagnosis code;
5. charge for service; and
6. name and address of Provider of service.

D. Claims for Nursing Services

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

E. Claims for Durable Medical Equipment (DME)

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

F. Claims for Mental Health and Substance Use Disorders

For help with filing a Claim for the treatment of Mental Health or substance use disorders, the Member should refer to the ID card or call Our customer service department.

G. Claims Questions

Members can view information about the processing or payment of a Claim at **www.bcbsla.com**. Members can also write Us at the below address or call Our customer service department at the telephone number shown on the ID card or visit any of Our local service offices*. If the Member calls for information about a Claim, We can help the Member better if they have the information at hand, particularly the contract number, patient's name and date of service.

Remember, the Member should ALWAYS refer to their contract number in all correspondence and recheck it against the contract number on the ID card to be sure it is correct.

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

*Our local service offices are located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

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, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@lablue.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries 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 Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to **www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

 Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana Inc. and Southern National Life Insurance Company Inc., are independent licensees of the Blue Cross Blue Shield Association.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)