CHRISTUS Health Plan

LOUISIANA HEALTH EXCHANGE

ON-EXCHANGE

2025 Evidence of Coverage

CHRISTUS HEALTH PLAN LOUISIANA ON-EXCHANGE COVERS MEMBERS IN THE FOLLOWING PARISHES:

- Bossier
- Caddo
- Calcasieu
- Grant
- Natchitoches
- Rapides
- Red River
- Vernon

NOTICE: Upon renewal of this Contract, your premium may increase. Please contact us for more information.

CHRISTUS Health Plan

CONTRACT AND EVIDENCE OF COVERAGE

Louisiana Health On-Exchange
Individual and Family Coverage

NOTICE: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

This Contract takes effect at 12:01 a.m. of the date on which the Member's coverage begins and terminates at 11:59 pm on the last day of the month for which premiums were paid and the date that the Member's coverage ends.

CHRISTUS HEALTH PLAN
5101 North O'Connor Boulevard
Irving, Texas 75039
Toll-Free Phone Number: 1-844-282-3025
www.christushealthplan.org

The Subscriber to whom the contract is issued may examine it and if you are not satisfied with it for any reason, you are permitted to return it within ten (10) days of receiving it and receive a refund of the premium paid. If services are rendered or claims paid during the ten (10) day examination period, you are responsible for repaying us for such services or claims. This consideration, including premiums, application fee, and any other amounts to be paid for coverage will be expressed in the agreement or in the application.

WELCOME TO CHRISTUS HEALTH PLAN

We are glad you have chosen CHRISTUS Health Plan. We have been serving you, your family and your community for 150 years. We are pleased to now serve you through our health plan.

When you join CHRISTUS Health Plan, you are joining a health plan that is part of a larger health system. Our health system is faith-based and not-for-profit. As a health system, we can coordinate your care. Whether you are healthy and want preventive care, need to see a doctor, or have a more serious health need, we are here to serve you. We believe that you, your family, and your community are critical to your well-being. We will engage you in your health care decisions and give you the tools and support you need to manage your health and benefits.

This Contract and Evidence of Coverage ("Contract") is offered by CHRISTUS Health Plan Louisiana, dba CHRISTUS Health Plan, a Louisiana licensed Health Maintenance Organization (HMO). This Contract describes your rights and benefits under this individual and family Health Maintenance Organization (HMO) Contract and CHRISTUS Health Plan. The Contract includes the *Schedule of Benefits* and is a legal contract between you, the Member (referred to as Member, you, or your) and CHRISTUS Health Plan (referred to as CHRISTUS Health Plan, we, our, and us). The *Summary of Benefits and Coverage* and the *Schedule of Benefits* are separate documents which are included in your welcome packet.

Throughout this Contract, please refer to your *Schedule of Benefits* provided with this Contract, which shows some specific covered benefits this Contract provides, the specific amounts you may have to pay (cost sharing), and certain coverage limitations and exclusions. The *Schedule of Benefits* is part of this Contract, and together the Contract and the *Schedule of Benefits* provide a full description of the covered benefits, exclusions, and conditions of the Plan.

PLEASE READ THIS CONTRACT CAREFULLY and keep this Contract, along with the *Schedule of Benefits* in a safe place that you can access quickly. Please also be aware that your physicians and providers do not have a copy of this Contract and are not responsible for knowing or communicating your covered benefits to you.

This Contract provides important information about:

- Your rights and responsibilities as a Member;
- Covered benefits under the Plan and how to access them;
- Limitations and exclusions from the Plan; and
- How to seek assistance from CHRISTUS Health Plan.

Key Terms Used in this Contract

Since this is a legal document, there are certain key terms that have special meanings. These terms are defined in the DEFINITIONS section of this Contract. Review this section carefully.

IMPORTANT PHONE NUMBERS AND ADDRESSES

Member Services	**Address:** CHRISTUS Health Plan Attn: Member Service Department 5101 North O'Connor Boulevard Irving, Texas 75039	**Toll-Free** **1-844-282-3025** **TTY** **7-1-1**
Preauthorization	**Address:** CHRISTUS Health Plan Attn: Preauthorization Department 5101 North O'Connor Boulevard Irving, Texas 75039	**Toll-Free** **1-844-282-3025** **TTY** **7-1-1**
Claims	**Address:** CHRISTUS Health Plan Exchange Attn: Claims Department P.O. Box 169012 Irving, Texas 75016	**Toll-Free** **1-844-282-3025** **TTY** **7-1-1**
Complaints, Appeals and Grievances	**Address:** CHRISTUS Health Plan Exchange Attn: Complaints, Appeals & Grievances Department P.O. Box 169009 Irving, Texas 75016	**Toll-Free** **1-844-282-0380** **TTY** **7-1-1**
Fraud, Waste and Abuse	**Email:** CHRISTUSHealthSIU@CHRISTUSHealth.org	**Toll-Free** **1-855-771-8072** **TYY** **7-1-1**
Website: www.CHRISTUSHealthPlan.org		
Language Access Services Toll Free 1-800-752-6096		

IMPORTANT NOTICE	AVISO IMPORTANTE
To obtain information or make a complaint: You may call CHRISTUS Health Plan's toll-free telephone number for information or to make a complaint at: **1-844-282-0380** You may also write to CHRISTUS Health Plan at: P.O. Box 169009 Irving, Texas 75016	Para obtener información o para presenter una queja: Usted puede llamar al número de teléfono gratuito de CHRISTUS Health Plan's para obtener información o para presentar una queja al: **1-844-282-0380** Usted también puede escribir a CHRISTUS Health Plan: P.O. Box 169009 Irving, Texas 75016
You may contact the Louisiana Department of Insurance to obtain information on companies, rights or complaints at: **1-800-259-5300** You may write the Louisiana Department of Insurance at: P.O. Box 94214 Baton Rouge, LA 70804-9214 Web: www.ldi.la.gov	Usted puede comunicarse con el Departamento de Seguros de Louisiana para obtener información sobre compañías, derechos, o quejas al: **1-800-259-5300** Usted puede escribir al Departamento de Seguros de Louisiana at: P.O. Box 94214 Baton Rouge, LA 70804-9214 Web: www.ldi.la.gov
PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Louisiana Department of Insurance.	**DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Louisiana.

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MEMBER RIGHTS AND RESPONSIBILITIES

CHRISTUS Health Plan wants to provide high-quality health care benefits to you. As a Member of the CHRISTUS Health Plan (Plan), there are rights that you are entitled to have. You also have some responsibilities. It is important that you fully understand both your rights and your responsibilities under this Contract. This section explains your rights and responsibilities under this Contract and how you can participate in our Consumer Advisory Board.

NOTICE TO MEMBERS OF NETWORK REQUIREMENTS

A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, you may file a complaint with the Louisiana Department of Insurance at www.ldi.la.gov.

If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

You may obtain a current directory of network physicians and providers at the following website: www.christushealthplan.org or by calling 1-844-282-3025 for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than thirty (30) days before you received the service. Please see section regarding appeals and complaints process section of this document for additional information.

Member Rights

As a Member of the Plan, you have the right to:

- Available and accessible services for medically necessary and covered services, including 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined by this Contract or the *Schedule of Benefits*.
- Be treated in a prompt, courteous and responsible manner that respects your dignity and privacy.
- Detailed information about your coverage; benefits; and services offered under this Contract. This includes any exclusions of specific conditions; ailments or disorders,

including restricted prescription benefits; the Plan's policies and procedures regarding products, services, providers appeal procedures and other information about the Plan and the benefits we provide to you. This also includes access to a current list of participating providers in the Plan's network; information about a particular participating provider's education, training, and practice; and the Member Rights and Responsibilities, as well as the right to make recommendations regarding our Member Rights and Responsibilities policies.

- Affordable health care including information regarding your out-of-pocket expenses; limitations; the right to seek care from a non-participating provider; and an explanation of your financial responsibility when services are provided by a non-participating provider or without prior authorization.
- Choose a Primary Care Provider within the limits of the covered services, the Plan's network, and as provided by the Contract, including the right to refuse care of specific health care professionals. In addition, you have the right to participate with your providers in making decisions about your health care.
- Be given an explanation of your medical condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives by your participating provider in terms that you understand. If you are unable to understand the information, an explanation must be given to your next of kin, guardian, or another authorized person. This information shall be documented in your medical records.
- All rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to be informed about your treatment by your participating provider in terms that you understand; to request your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of possible consequences of refusing such treatment. This right exists even if treatment is not a covered benefit or medically necessary under the Plan. The right to consent or agree to treatment by you or your next of kin, guardian, or another authorized person may not be possible in an emergency where your life and health are in serious danger.
- Voice complaints or appeals with the Plan or the Commissioner of Insurance (Commissioner) about the Plan or the coverage we provide. You as a Member also have the right to receive an answer within a reasonable time and in accordance with existing law and without fear of retaliation.
- Be promptly notified of termination or changes in benefits, services, or the provider network.
- Confidential handling of all communications, including medical and financial information maintained by the Plan. Privacy of your medical and financial records will be maintained by us and pur Providers in accordance with existing law.
- A complete explanation of why a benefit is denied, the opportunity to appeal the denial decision, to our internal review and the right to request help from the Commissioner.
- Know, upon request, of any financial arrangements or provisions between the Plan and our participating providers, which may restrict referrals or treatment options or limit the services offered to you.

- Qualified Health Care Professionals for treatment and services that are covered benefits near where you live or work within the Plan's service area.
- Receive information about how benefits are authorized or denied. You have the right to know how new technology for covered benefits are evaluated. You can also request and receive information about the Plan's quality assurance plan and utilization review methodology.
- Receive detailed information about all requirements that you must follow for prior authorization and utilization review.

Member Responsibilities

As a Member of the Plan, you have the responsibility to:

- Provide honest and complete information to those providing you care.
- Review and fully understand the information you receive about your Plan.
- Know the proper use of the services covered by the Plan.
- Present your Plan ID card before you receive care.
- Consult your physician before receiving medical care, unless your condition is life threatening.
- Promptly notify your provider if you will be delayed or unable to keep an appointment.
- Pay all charges or copayment amounts, including those for missed appointments. This also applies to deductibles and any charges for non-covered benefits and services.
- Express your opinions, complaints or concerns in a constructive way to CHRISTUS Health Plan Member Services or to your provider.
- Inform the Plan of any changes in family size, address, phone number or membership status within thirty (30) calendar days of the change.
- Make premium payments on time.
- Notify the Plan of other coverage.
- Follow our complaint and appeal process when displeased with the Plan or a providers' actions or decisions.
- Understand your health problems and participate in developing treatment goals that you agree to with your providers.
- Follow plans and instructions for care that you have agreed to with your provider.

You are responsible for understanding how the Plan works. You should carefully read this Contract and your *Schedule of Benefits*. Contact the Member Services department when you have questions about your Plan.

Marketplace (Exchange) Information

We can help you with questions about the Marketplace. You can also get information about the Marketplace by calling toll-free, 1-800-318-2596 or by visiting www.healthcare.gov/marketplace/index.html. The Marketplace can give you information about how You can get the most out of your benefits. They can also tell you how to contact a Navigator. Navigators are trained to tell you about the Marketplace and getting benefits that are available to you.

Electronic Communication

With your consent, we may deliver written communication to you by electronic means. Before you give consent, we will provide you notice that you may have materials or communications provided in paper or non-electronic format and how to request that information. ou may withdraw your consent at any time. your consent will tell us if you would only like a specific transaction sent electronically or if there are identified categories of information you would like to receive electronically.

The notice will also provide you information on how to withdraw your consent and how to update your contact information with us.

ELIGIBILITY AND ENROLLMENT

Eligibility

The Federal Exchange makes eligibility decisions from the application that you submit. You are responsible for telling the Exchange about any changes that could change your eligibility. Examples of changes are adoption, a birth, addition of another dependent, or a divorce. To be eligible for covered benefits with this Contract, you must be enrolled as a Member. A Member is the person who has applied for coverage on behalf of his/herself and his/her dependents, and to whom this Contract has been issued.

To enroll in CHRISTUS Health Plan, you must be a Qualified Individual:

- Be a citizen of the United States;
- Be lawfully present in the United States, if not a citizen of the United States;
- Be a qualified individual eligible for coverage through the Exchange.
- Not be incarcerated, other than incarceration pending disposition of charges;
- Be ineligible for Medicare due to age, illness or disability, other than individuals with end stage renal disease, or be over age sixty-five (65) and eligible for premium-free part A, but is not collecting Social Security benefits and has not enrolled in either Part A or Part B;
- You must reside in the CHRISTUS Health Plan service area, or the Subscriber must reside in the service area, and continue to meet these criteria.

Members who experience a decrease in household income and receive a new determination of eligibility for APTC by an Exchange are eligible to contact Healthcare.gov for a new Exchange based plan to receive APTC.

To add a newborn and other dependents to your Plan you must complete an enrollment form for the dependent and submit it to the Federal Exchange. You must tell us any time prior to the birth of a child or within thirty-one (31) days after the birth of a child that you wish to add as a Dependent and pay any premium required to continue the coverage. We will not exclude or limit coverage for a newborn child of the subscriber or subscriber's spouse; congenital defects will be treated the same as any other illness or injury for which coverage is provided. Your newborn child may receive services from non-participating providers if the newborn child is born outside the service area due to an emergency, or is born in a non- participating facility to a mother who does not have coverage. We may require that the newborn be transferred to a participating facility at our expense and, if applicable, to a participating provider when such transfer is medically appropriate.

Notwithstanding the Exchange notification eligibility requirements, a newborn child of the subscriber or the subscriber's spouse is entitled to coverage during the initial thirty-one (31) days following birth. You may notify CHRISTUS Health Plan, either verbally or in writing, of the addition of the newborn as a covered Dependent. In addition, grandchildren living with and in the household of the subscriber may also qualify as a Dependent.

To qualify, grandchildren must be:

- Younger than twenty-six (26) years of age; and
- In legal custody of and residing with the Member.

To be eligible as a Dependent, each dependent must meet the following criteria:

- Be a dependent of a qualified individual eligible for coverage through the Plan under Louisiana law;
- Be enrolled at the same time as the Member.

A Dependent is a Member's lawful spouse, or domestic partner, and children under age twenty-six (26). The term "child/children" includes:

- a natural child;
- a stepchild, legally or adopted child, including children who have become subject of a suit for adoption of the Member or the Members' spouse or domestic partner;
- a grandchild who is in the legal custody of and residing with the grandparent; or
- a child for whom the Member or the Member's spouse or domestic partner are the legal guardian;
- an unmarried child who is placed in the home of an insured following execution of an act of voluntary surrender in favor of the insured or the insured's legal representative, for whom the date after which the act of voluntary surrender becomes irrevocable has passed.

Unless special circumstances apply, coverage of such Dependents is limited to those under the age of twenty-six (26). Dependents over the age of twenty-six (26) may qualify for continued dependent coverage if the Dependent is incapable of self-sustaining employment due to an intellectual or physical disability, and who is chiefly dependent upon the subscriber for support and maintenance. You must submit proof of the child's intellectual or physical disability and dependency to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent. Once a year, we may require proof of the continuation of the child's disability and dependence after the two-year period following the child's attainment of the limiting age.

Any child(ren) for whom you are the permanent legal guardian must be supported pursuant to a court order imposed on ou (such as a Qualified Medical Child Support Order). We will provide coverage to Dependent children as required due to a Qualified Medical Child Support Order in accordance with applicable federal or state laws or regulations. These Dependents are not bound by enrollment season restrictions.

Children subject to a Qualified Medical Child Support Order are also eligible for dental benefits under this Contract.

The Rights of Custodial Parents

If a Dependent child has coverage under a noncustodial parent, or a parent that does not have primary custody of the child, we will provide information to the custodial parent, as necessary, for the child to obtain benefits; permit the custodial parent or the provider to submit claims for

covered services without the approval of the noncustodial parent; and make payments on claims submitted in accordance with Louisiana law directly to the custodial parent, the provider or the state medicaid agency.

The Rights of Non-Custodial Parents
Non-custodial parents of children who are covered under a custodial parent's Contract have rights, unless those rights have been taken away by a court order or divorce decree. Non-custodial parents are able to contact us to obtain and provide necessary information including but not limited to provider information, claim information, claims payment, and benefits or services information for the child.

Enrollment
Online enrollment for the Exchange is available at www.christushealthplan.org.

Initial Enrollment
Coverage under this Contract shall become effective as of the date approved by CHRISTUS Health Plan.

Special And Limited Enrollment for Qualified Individuals participating in the Exchange

A Qualified individual has sixty (60) days to enroll as a result of one of the following events:

- A qualified individual or Dependent suffers a loss of minimum essential coverage;
- A qualified individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order;
- An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
- A qualified individual's enrollment or non-enrollment in a qualified Health Plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such
- Action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- An enrollee adequately demonstrates to the Exchange that the Qualified Health Plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Federal Premium Tax Credit (APTC) or has a change in eligibility for Federal Cost-Sharing Reductions, regardless of whether such individual is already enrolled in a Qualified Health Plan;
- A Qualified Individual or enrollee gains access to new Qualified Health Plans as a result of a permanent move;
- Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;

- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month;
- Enrollment in any non-calendar year group or individual health insurance coverage;
- Loss of pregnancy-related coverage or loss of access to health care services through coverage provided to a pregnant woman's unborn child;
- Loss of medically needed coverage;
- A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;
- A qualified individual is one that in the case of marriage, at least one spouse must demonstrate having minimum essential coverage;
- A qualified individual or enrollee is a victim of domestic abuse or spousal abandonment; including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or
- A qualified individual or enrollee applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event.

Loss of Minimum Essential Coverage means in the case of a Member who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan). Loss of eligibility for coverage includes, but is not limited to:

- Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
- In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside in a service area, loss of coverage because an individual no longer resides in the service area (whether or not within the choice of the individual);
- A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
- In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
- In the case of an employee or dependent that has COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Qualified Individuals that enroll between the first (1^{st}) and fifteenth (15^{th}) day of the month will have a coverage effective date of the first day of the following month. Qualified individuals that enroll between the sixteenth (16^{th}) and last day of the month will have a coverage effective date of the first day of the second following month.

In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption, or placement for adoption. Advance payments of the Federal Premium Tax Credit (APTC) and Federal Cost-Sharing Reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

The effective date of coverage for Dependents enrolled due to a Qualified Medical Child Support Order is the first of the month following receipt of the order or the effective date of the order, not to exceed sixty (60) days retroactive coverage. In the case of marriage, or in the case where the qualified individual loses minimum essential coverage, the effective date is the first day of the following month.

The Exchange may provide a coverage Effective Date for a Qualified Individual earlier than specified in the paragraphs above, provided that either:

- The Qualified Individual has not been determined eligible for Advance Payments of the Federal Premium Tax Credit or Federal Cost-Sharing Reductions; or
- The Qualifi
-
- ed Individual pays the entire Premium for the first partial month of coverage as well as all Cost Sharing, thereby waiving the benefit of Advance Payments of the Federal Premium Tax Credit and Federal Cost-Sharing Reduction payments until the first of the next month.

Notification of Change of Status
Any change in a Member's status after the effective date of coverage should be reported to Member Services. Changes may also be cause for a change in premiums. Examples include:

- Change in address or contact information;
- Change in eligibility status; or
- Change in tobacco use.

In the event of a change in marital status, that person shall be issued coverage in accordance with Louisiana statute.

Modification of Coverage
The Plan may modify coverage only if each of the below is met:

- The modification is at the time of renewal
- The modification is approved by the commissioner, is consistent with state law, and is effective among all individuals
- Notification is provided no later than the sixtieth (60) day before the date the modification becomes effective.

Cancellation of Coverage
A Member's coverage will end under this Contract on the earliest of the following dates when:

- The premium is not received by CHRISTUS Health Plan when due, subject to the Grace Period provision of this Contract.
- After not less than sixty (60) days written notice, the Member no longer resides in the service area; except that CHRISTUS Health Plan will not cancel the coverage for a child who is the subject of a medical support order because the child does not reside, in the service area;

- The Plan or a particular type of individual coverage is terminated; but only if coverage is terminated uniformly without regard to any health status-related factor of Members and dependents of Members who may become eligible for coverage. We may cancel terminate coverage after ninety (90) days written notice and must offer each Member on a guaranteed-issue basis any other individual basic health care coverage offered by us in that service area. In case of termination by discontinuance of all individual basic health care coverage by the HMO in that state, but only if coverage is discontinued uniformly without regard to health status-related factors of Members and dependents of Members who may become eligible for coverage, the HMO may cancel coverage after 180 days' written notice to the commissioner and the Members , in which case the HMO may not re-enter the individual market in Louisiana for five years beginning on the date of discontinuance at the last coverage not renewed.
- The Member is no longer eligible for coverage through the Exchange;
- The Member obtains other coverage through the Exchange;
- The Member engages in fraud or intentional misrepresentation of a material fact in the enrollment application, after not less than a thirty (30) day written notice;
- The Member engages in fraud in the use of services or facilities, after not less than a thirty (30) day written notice.

Coverage will end on at 11:59 pm on the last day of the month for which premiums were paid. The Member will be responsible for claims paid after the Termination Date.

We will not pay for any covered services provided to a Member or Dependent after the date of termination. Unless we agree, in writing, no covered benefits will be provided under this Contract following the date this Contract terminates, including if your or your Dependent are or remain in the hospital after the date of termination of this Contract.

Conversion of Coverage

Eligible Dependents under this Contract have a right to a conversion to a new Contract upon:

- The death of the Member; or
- Divorce, annulment or dissolution of marriage or legal separation of the spouse from the Member.

The right to conversion does not apply if:

- Coverage ends due to non-payment of premium,
- The Dependent is eligible for or enrolled in Medicare.

The Dependent must tell us of their desire to convert their coverage. We will then send notice of conversion rights. The Dependent must pay the applicable premium within thirty (30) days following receipt of the notice of conversion rights sent by us.

A Dependent who becomes a Member under the new Contract must continue to reside in the service area. Dependents of the Member are not required to reside in the services area. The conversion plan will be the same form of coverage then being offered by CHRISTUS Health

Plan that the original Member and his/her Dependents had, prior to conversion. Premiums must be paid on time. If the Dependent wishes to enroll on a different benefit plan, he/she may have to reapply for coverage.

HOW YOUR PLAN WORKS

This section explains how your Plan works, how to access your Primary Care Provider to get healthcare, and the rules you must follow when getting care.

The Plan is an "HMO" style plan, which means that you select a Primary Care Provider (PCP) to arrange all of your care. The Plan also requires that:

- You must live, reside, or work in the service area, unless you are a Dependent, and meet all the rules for coverage in this Contract.
- You must receive healthcare services by our network of participating providers. Our network is made up of doctors and hospitals that we contract with to provide you medical services.
  If you do not use our network of participating providers, you may have to pay for the services you receive.
- You may obtain covered services from a non-participating provider only when a participating provider is not available within the service area. To get an authorization for these covered services, your PCP will submit a referral request to us. Emergency care services are covered even if the provider is not a participating provider.
- You must pay your cost sharing at the time you receive covered services. We will pay the provider the balance due for covered services. Your *Schedule of Benefits* has more information on the cost sharing requirements.
- Some healthcare services will require preauthorization to be covered under the Plan. For example, preauthorization is required for hospitalizations and some types of outpatient care.
- Your participating provider must make sure that preauthorization is in place when it is needed. Please read the HOW PREAUTHORIZATION WORKS section of this Contract for more details.
- Emergency care services outside the service area are covered, but other types of care may not be covered.

Primary Care Providers
A good relationship with your Primary Care Provider (PCP) will help you and your family make the most of your Plan benefits. As our Member, you can select a PCP for yourself and each covered Dependent. You may consult our online provider directory by visiting our website at www.christushealthplan.org, or call Member Services at 1-844-282-3025. We can help you choose a PCP that is a part of our provider network.

If you do not choose a PCP when you enroll, a PCP near your home will be selected for you. You do not have to use the PCP we automatically assign to you. Please call Member Services at 1-844-282-3025 to change your PCP.

PCPs can include family practice physicians; general practitioners; internists; pediatricians; obstetricians and/or gynecologists (OB/GYN). Each Member may choose what type of PCP they prefer. Female Members may choose to have an OB/GYN as their Primary Care Provider, if

desired. For female Members who do not choose an OB/GYN as their PCP, no referral is required for services provided from OB/GYN participating providers. Your PCP is responsible for providing your Primary Care Services. These include annual examinations, routine immunizations, and treatment of non-emergency acute illnesses and injuries. A female member may also select an OB/GYN in addition to a PCP.

If you are a new Member and have a medical problem or are on medication, you should contact your PCP's office. You should arrange for an appointment as soon as possible following your effective date.

Specialist as PCP
Some specialists may act as a PCP for Members with a severe chronic, disabling, or life-threatening medical condition. This is permitted if the specialist provides all basic health care services and they are contracted with CHRISTUS Health Plan to perform PCP duties. Contact Member Services at 1-844-282-3025 to find out which providers serve in both roles.

CHRISTUS Health Plan Provider Directory
Our provider directory is a list of physicians, hospitals, pharmacies, and other providers that are contracted with us. The provider directory is updated regularly.

You can see the online provider directory on our website at www.christushealthplan.org. You can also call Member Services at 1-844-282-3025 and ask about a participating provider.

ID Card
You have been sent a Plan ID card. If more cards are needed, you may download and print copies from your online Member Portal, or you can call Member Services at 1-844-282-3025. Always carry your Plan ID card with you. The Plan ID card lists some of those benefits to which Members are entitled that may require copayment amounts. Cost sharing information can be found in your *Schedule of Benefits*.

You are entitled to Plan benefits for covered services if all premiums, deductibles and copayment amounts have been paid and you are eligible to get Plan benefits. Possession of a Plan ID card alone does not entitle you to benefits. Do not allow others to use your Plan ID card. By doing so, you must pay for the services given to the non-Member. In addition, your Plan membership and that of your covered Dependents, may be terminated. Call Member Services at 1-844-282-3025 immediately if your Plan ID card is lost or stolen.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification (ID) Cards
WARNING: It is important to follow the advice of medical professionals and to receive the best care and treatment possible. This section does not provide any guidance or advisement for medical treatment and may not be interpreted as prescribed medical services. Do not use any information in this section to make decisions about your health care needs.

This section is designed to provide general information to protect against the unauthorized use of your medical benefits and ID card. The information can help raise awareness of strategies used by unscrupulous people to take advantage of you for financial gain. Also, in the event there is use of your ID card or health care benefits for anyone other than you, you are asked to make a report using the phone, fax or email listed in the next paragraph.

The use of your ID card or Personal Health Information by anyone else, whether you know him/her or not, may be considered fraud and must be reported immediately to the CHRISTUS Fraud Hot Line 855-771-8072, Fraud secure fax 210-766-8849 or dedicated email CHRISTUSHealthPlanSIU@CHRISTUSHealth.org.

Please report any occurrence of the following:

- A health care provider bills for medical treatment, services or equipment you did not receive, or on a date other than the date of treatment.
- A health care provider or other person offers you cash, a gift card or other benefits in exchange for you visiting a specific health care provider.
- If you are solicited with an offer for free treatment at an inpatient sober living house, whether in state or out of town.
- A health care provider bills an excessive amount for treatment you received, even if you paid your normal deductible.
- A health care provider performs treatment or services that are medically unnecessary and unrelated to any condition for which you sought treatment.
- A health care provider asks you to recruit family or friends for any treatment or services.
- You continue to receive ongoing delivery of medical equipment you no longer need or use. (Please DO NOT stop any prescribed treatment without consulting a medical professional)
- Your treatment period lasts significantly longer than the prescribed time period or appears to have no end date, or no Plan of Care has been presented to you.
- Your treatment is abnormally spread out over multiple visits without any medical reason.

The unauthorized, fraudulent, improper, or abusive use of ID cards issued to Members include, but are not limited to, any of the following actions, when intentional:

- Use of the ID card prior to your effective date;
- Use of the ID card after your termination of coverage under the Plan;
- Obtaining prescription drugs or other benefits for persons not covered under the Plan;
- Obtaining prescription drugs or other benefits that are not covered under the Plan;
- Obtaining prescription drugs for resale or for use by any person other than the person for whom the drugs are prescribed, even though the person is otherwise covered under the Plan;
- Obtaining prescription drugs without a prescription or through the use of a forged or altered prescription;
- Obtaining quantities of prescription drugs in excess of medically necessary or prudent standards of use or in circumventions of the quality limitations of the Plan;

- Obtaining prescription drugs using prescriptions for the same drugs from multiple providers; or
- Obtaining prescription drugs from multiple pharmacies through the use of the same prescription.

The fraudulent or intentionally unauthorized, abusive, or other improper use of ID cards by any Member can result in, but is not limited to:

- Denial of benefits;
- Cancellation of coverage;
- Limitation on the use of the ID card to one designated physician, other provider, or in-network pharmacy;
- Recoupment from you of any benefit payment made;

Pre-approval of drug purchases and medical services; or

- Notice to proper authorities of potential violations of law or professional ethics.

YOUR COST SHARING OBLIGATIONS

Cost sharing is the share of the cost that you pay for covered benefits under the Plan. The cost sharing payments under your Plan include the annual deductible, coinsurance and copayment amounts for each type of service as listed in your *Schedule of Benefits*.

Annual Deductible
Certain services are subject to an annual deductible. This is the amount a Member must pay each calendar year for covered services before some covered services are paid under this contract. It is also referred to as the deductible. Please refer to your *Schedule of Benefits*.

Not all covered services are subject to the deductible such as most preventive services. Your Plan's copayment amounts do not apply towards your deductible. Please refer to your *Schedule of Benefits* for your Plan's deductible amounts and for information about which services are not subject to the deductible.

Copayments and penalties are not considered when determining if you have satisfied your deductible.

Per-Person Deductible
You have an individual deductible. Once your individual deductible has been met, the Plan will pay benefits for your covered services. Refer to your *Schedule of Benefits* for your deductible amount.

Family Deductible
If you have enrolled in family coverage, or coverage for two (2) or more people; your Plan has a family deductible. Some covered services will not be eligible for payment by the Plan until either the per-person deductible or the family deductible has been met. Amounts paid by any Member

in your family toward their per-person deductible will also apply to the family deductible. For example, if the individual Member's per-person deductible is $500, then up to $500 per Member can be applied to the family deductible. Once the family deductible has been met, no per-person deductible will apply and we will pay for covered services.

Changes to the Deductible
Changes to the deductible may only be made at renewal.

Annual Out-of-Pocket Maximum
Your Plan includes an annual out-of-pocket maximum to protect you and your dependents from the high cost of a catastrophic event. The annual out-of-pocket maximum is the most you will pay for cost sharing in a calendar year for certain covered benefits. Please refer to your *Schedule of Benefits* for the out-of-pocket maximum.

Only deductibles, coinsurance, and copay amounts paid out of your pocket for covered benefits are applied to the annual out-of–pocket maximum. Once this amount is met then covered benefits are paid at 100% for the remainder of the calendar year.
Deductibleand copay amounts paid for vision services that are not essential health benefits do not apply toward this Plan out-of-pocket maximum as well.

Once your deductible is satisfied, the copay payments that you pay for covered services will continue to apply to your out-of-pocket maximum. Amounts or services that do not apply to your out-of-pocket maximum are:

- Penalty amounts;
- Premium payments; and
- Amounts paid for non-covered benefits.

Per Person Out-of-Pocket Maximum
If you have single coverage, you have an individual per person out-of-pocket maximum to meet. Once you have met this amount, covered benefits are paid at 100% for the remainder of the calendar year.

Family Coverage Out-of-Pocket Maximum
For Members who have family coverage, there is a family out-of-pocket maximum. Each individual Member's per-person out-of-pocket maximum applies until the family out-of-pocket maximum has been met. Any combination of family members can contribute toward meeting the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, covered benefits are paid at 100% for the remainder of the calendar year. For example, if the individual Member's per person out-of-pocket maximum is $2,000, then up to $2,000 per Member can be applied to the family out-of-pocket maximum. Any remaining amount on the family out-of-pocket maximum must be satisfied by other family members.

If you have questions, or wish to report that you have reached your out-of-pocket maximum, please contact Member Services at 1-844-282-3025.

Coinsurance
The coinsurance is the percentage of costs of a covered service as shown on your *Schedule of Benefits*. You pay a percentage (20%, for example) after you have satisfied your deductible.

Copayments
The copayment or copay is the amount shown on your *Schedule of Benefits* that must be paid by you directly to the provider each time certain covered services are received.

Copays may be due for each service your Provider conducts, even if you have more than one appointment in the same day. Copays do not apply toward the deductible.

If you are unsure of the benefits covered under your Plan or the cost sharing amounts, please contact Member Services at 1-844-282-3025.

No Surprises Act
When you get emergency care or get treated by an out-of-network provider at an in-network hospital, hospital outpatient department, critical access hospital, ambulatory surgical center, and any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan, you are protected from surprise billing or balance billing. When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan.

Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

When balance billing isn't allowed, you also have the following protections: You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).

Your health plan will pay out-of network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Certain Ancillary Services

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Providers may no longer balance bill an individual for emergency services. A provider will only be able to balance bill an individual for certain post-stabilization services, and for services performed by nonparticipating providers at certain participating facilities, if the provider or facility provides notice to the participant, beneficiary, or Member , and obtains the individual's consent to receive care on an out-of-network basis and be balance billed. Further, CHP has made provisions to ensure all relevant civil rights protections are upheld and communication is accessible and understandable, to you the Member. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

HOW TO SEEK HEALTH CARE

The Plan has a network of doctors, healthcare facilities, labs and pharmacies. This section of the Contract explains how and where you can get care. Please also refer to the *Schedule of Benefits* attachment to this Contract for specific information.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE 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 THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

When you need care:

- Contact your Primary Care Provider (PCP).
- Identify yourself as a Member. Your PCP may ask for information on your Member ID Card, so have it ready.
- At the healthcare visit, show your Member ID Card.
- If necessary, get a preauthorization from your PCP for certain covered benefits. More information on this is available in the HOW PREAUTHORIZATION WORKS section of this Contract.

Please contact Member Services at 1-844-282-3025 if you have any questions or wish to file a complaint.

Emergency Care

If you have an emergency, you should call 911, or seek treatment at the nearest emergency facility, whether or not it is a participating provider. An emergency is any medical problem that you reasonably believe could cause death or permanent injury if not treated quickly.

If you are able, tell the emergency room staff that you are a Member and provide them your Member ID Card.

Emergency care services may be required to treat an accidental injury or the sudden onset of a medical condition causing severe symptoms such as new, severe pain. A reasonable layperson would expect the lack of immediate medical attention to result in jeopardy to a Member's health, impairment of bodily functions, serious dysfunction of a bodily organ or part, disfigurement to a person, or for a pregnant woman, serious jeopardy to the health of a fetus.

Emergency care services may also be required to treat conditions that may become more serious or life threatening if not treated promptly, such as severe bleeding, severe abdominal pain, chest pain, a severe eye injury, or the sudden inability to breathe.

If you seek emergency care for an illness or injury that you believe requires immediate medical attention, the services will be covered by your Plan. Emergency care does not require preauthorization. However, if your emergency causes you to be admitted to the hospital, notification and authorization will be required for your hospital admission.

We will pay the provider at a rate that we agree upon with the provider. If you receive a balance bill from a non-participating provider, contact us.

Emergency Care Services at a Non-Participating Provider or Facility
In an emergency, you should go to the nearest available provider or facility. You do not need preauthorization to get Emergency Care Services from participating and non-participating providers.

Emergency Care Services you get from non-participating providers will be paid by us at the maximum amount payable as described below in the section entitled "Costs for Non-Participating Providers". However, you may be transferred to a participating provider for continued care if it is medically wise to do so. You will pay the same cost sharing you would pay for a participating provider. If you receive a balance bill from a non-participating provider, contact us.

Make sure you contact us and we will determine in consult with your provider if arrangements should be made to transfer you. If you receive non-emergency follow-up care from an out-of-network provider after you are discharged, you will be responsible for the cost of those services.

Non-emergency care services, such as follow-up care from a prior emergency require preauthorization from the Plan. If you do not receive preauthorization for non-emergency care services that require preauthorization, we will not pay for the services that you receive.

All inpatient admissions require preauthorization by us, except as set forth in maternity care. If you are admitted to a non-participating or out–of-network facility, you must contact the Plan for preauthorization. An authorized family member or caregiver should contact us if you are not able to do so. Preauthorization is needed in order for covered services to be paid at the highest benefit level. Upon receiving preauthorization and admission, a physician other than your PCP may direct and oversee your care.

Urgent Care
Urgent Care includes medically necessary services provided to treat urgent illness or injury that are not life-threatening but may require prompt medical attention. Care that is needed after a Primary Care Provider's normal business hours is also considered to be urgent care.

Members are encouraged to contact their Primary Care Provider for an appointment before seeking care from another provider. If the Primary Care Provider is not available and the condition persists, call the Nurse Advice Line at 1-844-581-3175. The Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A Registered Nurse can help you decide the kind of care most appropriate for your specific need.

A few examples of urgent illness or injury are:

- Sprains or a possible broken bone;
- A cut that may need stitches;
- A rising fever;
- Severe vomiting or diarrhea;
- Ear pain; and
- Flu symptoms.

Urgent care is not limited to these situations. If you need assistance finding an urgent care provider, please contact Member Services at 1-844-282-3025.

Contact your PCP for an appointment before seeking care from another provider. If PCP is not available and the condition persists, call the Nurse Line toll-free at 1-844-581-3175.

The Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A Registered Nurse can help you decide the kind of care most appropriate for your specific need.

Office Visits
Physicians and other providers who you see in an office setting will provide you with both primary care and specialty care services. These covered services may include annual examinations, routine immunizations, and treatment of non-emergency/acute illnesses and injuries. For preventive, routine or specialty care, call or make an appointment with your physician or other provider. Your provider will arrange for preauthorization as needed.

If you need a same day appointment or have an urgent illness, call your Physician's office to make an appointment. If your Provider is unable to see you, you may be offered an appointment with another physician, certified Nurse Practitioner or Physician Assistant in his/her group. After hours, your physician may offer an answering service.

When you arrive for your appointment show your Plan ID card to the receptionist. You may be required to make a copay before receiving services. If you are unable to keep an appointment,

cancel as soon as possible, as missed appointment charges may apply and those charges are not covered under the Plan.

Telehealth services are covered services under this Contract at the same level and copayment amounts as other office visits.

Ambulance Service
If you need an Ambulance, call 911 or a local Ambulance service. This service is covered if it is medically necessary because of an emergency. The Plan's Medical Director determines this by reviewing Ambulance and medical records.

Non-Emergency Ambulance transport requires preauthorization from the Plan. If ambulance services are not medically necessary and are not authorized by the Plan, you are responsible for payment.

Continuity of Care
If you are receiving an ongoing course of treatment from a participating provider whose contract ends during an on-going or active course of treatment, you may be eligible to continue to receive services as though your provider was still a participating provider. This is called continuity of care.

A continuing-care patient means an individual who: (A) is undergoing a course of treatment for a serious and complex condition from the provider or facility; (B) is undergoing a course of institutional or inpatient care from the provider or facility; (C) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; (D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (E) is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

The Plan will continue to cover covered services until the latest of: (a) the ninetieth (90th) day after the effective date of termination from the provider network; (b) if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination; or (c) if the Member is pregnant at the time of termination, through delivery of the child, immediate post-partum care and the six week follow up checkup.

For New Members
If you are receiving an ongoing course of treatment with a provider that is not within the CHRISTUS Health Plan provider network, you may be able to receive services from that provider and have them paid for at the participating provider benefit level. Members with certain conditions may request for continuity of care from us within thirty (30) days of the date of enrollment.

For Existing Members
If your Provider's contract with CHRISTUS Health Plan ends during your course of treatment, you may be eligible to continue seeing that provider. Existing Members with certain medical conditions may be eligible for continuity of care. This transitional period will allow a Member to have continued access to a provider. You do not need to request for care to be continued since care is coordinated through the Plan.

Access to Non-Participating Providers
If a covered service is medically necessary and is not available through a participating provider, we will refer you to a non-participating provider no more than five business days after receipt of your request and documentation, or sooner depending on your condition. We will coordinate the referral. **You must have our approval before receiving the services, or you will be responsible for payment.**

The Allowable Charge is the amount that we have determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Non-Participating Providers, the amount payable will be either a rate agreed upon by Us and the Non-Participating Provider, or based upon Our out-of-network fee schedule. Our out-of-network fee schedule is based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflects market rates, including geographic differences in costs, and is consistent with nationally recognized and generally accepted bundling edits and logic.

We will pay the provider at the usual and customary rate or at a rate that we agree upon with the provider. You will pay the same cost sharing You would pay for a participating provider. If you receive a balance bill from a non-participating provider, contact us.

Before we deny a referral to a non-participating provider, we will ensure that the request is reviewed by a specialist that is familiar with your medical condition and is of the same or similar specialty as the physician or provider on your referral request.

Facility-Based Providers
A facility-based provider may not be a participating provider. These non-participating providers may not balance bill you for amounts not paid by us. If you receive a balance bill from a non-participating or participating facility-based provider, contact us.

When giving notice and seeking consent from individuals to waive their balance billing protections under the No Surprises Act, providers and facilities must use standard notice and consent documents developed by HHS.

- If an individual schedules an appointment at least seventy-two (72) hours before the date of the appointment, notice and consent documents must be given to the individual no later than seventy-two (72) hours before the date of appointment.

- If an individual schedules an appointment within seventy-two (72) hours of the date of the appointment, notice and consent documents must be given on the day the appointment is made, but at least three hours before the time when items or services are to be provided.

Costs for Non-Participating Providers
The allowable charge is the amount that we have determined to be the maximum amount payable for a covered service. For covered services provided by non-participating providers, the amount payable will be either a rate agreed upon by us and the non-participating provider, or based upon our out-of-network fee schedule. This does not prevent you from balance billing. The out-of-network fee schedule is the usual and customary rate based on CHRISTUS's median amount negotiated for in network services, and consistent with nationally recognized and generally accepted bundling edits and logic. Our out-of-network fee schedule is based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflects market rates, including geographic differences in costs, and is consistent with nationally recognized and generally accepted bundling edits and logic. You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. The allowable charge is simply designed to limit the effects of using an out-of-network provider.

These Non-Participating Providers may not balance bill you for amounts not paid by us. If ou receive a balance bill from a Non-Participating Provider, contact us.

If the Member is approved to see the out of network provider, cost sharing will be considered as part of deductible and out of pocket cost. If the Member is not approved for the out of network care, this will not apply.

State of Emergency
If you have a disease or condition that requires life-sustaining treatments (such as chemotherapy, radiotherapy, dialysis, or heart surgery), and you have been forced to temporarily relocate to another state when the governor declares a state of emergency following a storm, we will continue to provide coverage for those life sustaining treatments as though they were in-network.

HOW PREAUTHORIZATION WORKS

Under your Plan, some healthcare services are not covered benefits unless you have preauthorization. This section explains the preauthorization process and explains what services require preauthorization. **This is not a complete list.** You can get information on our website at www.christushealthplan.org or by calling Member Services at 1-844-282-3025.

What is Preauthorization?
Preauthorization is a clinical review process where we review your case to determine if a service is medically necessary and a covered benefit before that service is provided to you.

Our medical director or other clinical professionals will review the healthcare service, your medical information, the place of treatment, and other information to decide whether to approve the proposed care.

Without Preauthorization, the proposed healthcare service may not be covered.

If you have questions about the preauthorization process or what services require preauthorization, please contact Member Services at 1-844-282-3025.

How Do You Get Preauthorization?
When a participating provider recommends care that needs to be preauthorized, it is up to that provider to contact us for the approval. Your provider is required to notify us and obtain approval prior to receiving these services. We may need to discuss details of the requested treatment or service with your provider.

If you need to obtain covered services from a non-participating provider, it is your responsibility to obtain any necessary preauthorization for those services. If you do not obtain preauthorization where it is required, your care may not be covered by us.

After preauthorization has been requested and all required documentation has been submitted, We will notify you and your provider if the request has been approved. We will also tell you and your provider if continued review of the Member's services will be required during the course of treatment.

To make sure that we have processed a preauthorization, call Member Services at 1-844-282¬3025. Please call at least fourteen (14) days before getting the services. If we do not issue a preauthorization, the claim may be denied.

How Does The Process Work?
When we receive a request for preauthorization, our clinical staff reviews the request using nationally recognized guidelines. These guidelines are consistent with sound clinical principles and have been developed by the Plan and practicing health care providers. If guidelines do not exist for a certain service or treatment, resource tools based on peer-reviewed, scientific medical evidence are used.

A preauthorization will specify the length of time for which it is valid. If your Preauthorization is approved, it will remain valid for 3 months. A preauthorization may also be for only a certain number of treatments or services.

Preauthorization for Cancer Patients
For any services typically covered under the plan and related to the diagnosis or treatment of cancer for which prior authorization is required, We shall offer an expedited review to Your Provider requesting prior authorization and communicate Our decision on the prior authorization

request as soon as possible, but in all cases no later than two business days from the receipt of the request for expedited review, and no later than five days on a request for which we do not receive a request for expedited review. If additional information is needed and requested for us to make a determination, we shall communicate our decision to Your Provider as soon as possible, but no later than forty-eight hours from receipt of the additional information.

We shall not deny a request for preauthorization or the payment of a claim for any procedure, pharmaceutical, or diagnostic test used for the diagnosis and treatment of cancer if it is recommended by a nationally recognized clinical practice guideline or consensus statement for your particular type of cancer and clinical state. We may require utilization review to assess the effectiveness of the procedure, pharmaceutical, or test for your condition.

What Services Require Preauthorization?
These services need preauthorization and are subject to the coverage rules in this Contract:

This is not a complete list

- All Inpatient Acute Care Hospitalizations, including post-stabilization services, except as set forth in Maternity Care;
- All Inpatient Rehabilitation Hospitalizations;
- All Subacute Facility Admissions;
- All Inpatient Long Term Acute Care Hospitalization;
- Clinical Trial Services;
- Cosmetic or Reconstructive Surgery;
- Durable Medical Equipment;
- Genetic Testing and counseling and treatment of Genetic Inborn Errors of Metabolism Disorders (IEM);
- Home Health Care;
- Hospice Services, Inpatient and outpatient;
- Medically Required Dental Services (this excludes Covered Preventative and Routine Pediatric Dental Services);
- MRI, CT Scan or other imaging procedures;
- Non-Emergency Ambulance transport;
- Organ Transplant Services;
- Outpatient Physical Therapy;
- Outpatient Occupational Therapy;
- Pain Management;
- Prosthetic Appliances and Orthotics;
- Other services provided during a Medical Office Visit
- Skilled Nursing Facility Care; and
- Surgical Procedures.

This list may not include all services requiring preauthorization. If you need help determining if a service requires preauthorization, contact Member Services at 1-844-282-3025.

Preauthorization for Prescription Drugs and Intravenous Infusions
Preauthorization is needed for certain prescription drugs and intravenous infusions. restricted drugs, other prescriptions or intravenous infusion that are not on the *Formulary*, but which are determined to be medically necessary and appropriate by the provider, may be submitted for preauthorization to the Pharmacy Exceptions Center via fax, phone or mail with appropriate documentation to support medical necessity.

If you do not get this approval, your drug or intravenous infusion might not be covered by the Plan. Please contact Member Services at 1-844-282-3025 for more information.

Decisions About Preauthorization's for Prescription Drugs and Intravenous Infusions
If our clinical staff is not able to approve your preauthorization for clinical reasons or non-*Formulary* drugs, your case will be referred to our Medical Director. The Medical Director will look at your case and review information sent to us by your provider. Our Medical Director may speak with your provider for more information.

You and your provider will be told in writing or by electronic means if preauthorization is approved.

You and your provider will be told by phone or other means, depending on the services requested, if the request for preauthorization cannot be approved based on the information we received, or if your Plan does not cover the service.

Appeal for Prescription Drugs and Intravenous Infusions
Standard/Non-Emergency Care Services
We will evaluate non-emergent appeal requests and notify you and your Provider of our decision within seventy-two (72) hours following receipt of an appeal for prescription drugs and intravenous infusions.

Expedited/Review of Ongoing Services
We will evaluate expedited appeal requests based on exigent circumstances. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-*Formulary* drug. We will make expedited appeal decision and notify you and your provider by telephone or electronic notification of the decision no later than twenty-four (24) hours following receipt of the request for **Prescription Drugs and Intravenous Infusions**, and we will follow with a letter within forty-eight (48) hours after the plan provides the initial telephone or electronic notification.

We will notify you and your provider of an expedited decision within twenty-four (24) hours of our receipt of a written or verbal request.

NOTE: Emergency Care and In-Network Urgent Care do not require Preauthorization.

External Review
You, an individual acting on your behalf, or your provider has the right to request an immediate external review of our appeal decision. You do not have to exhaust our appeal process before asking for an external review if the appeal process timelines are not met or if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-*Formulary* drug. Our notice of determination of the appeal will include complete instructions for making a request for an external review. Expedited external review may be initiated at the same time as expedited internal appeals.

We will issue an urgent care decision to you no later than twenty-four (24) hours from receipt of the request for external review and no later than seventy-two (72) for standard request. There is no cost to you for the external review.

A PREAUTHORIZATION DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID.

- You must be eligible for coverage and covered by this Contract on the date services are provided.
- All the terms of this Contract determine whether a serviced is a covered benefit.
- A Member shall not rely on verbal communications from a representative of CHRISTUS Health Plan that conflict with the written terms of this Contract.

In any instance where a verbal communication from a representative of CHRISTUS Health Plan differs from the terms of this Contract, the terms of this Contract shall prevail.

COVERED BENEFITS

Your Plan offers coverage for many Health Care Services. This section gives you the details about your covered benefits and other requirements, limitations and exclusions. You must pay your deductible, coinsurance and copayment.

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE 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.

Specifically Covered
Your Plan helps pay for health care expenses that are medically necessary and specifically covered in this Contract. Specifically covered means only those Health Care Services that are expressly listed and described in the benefits sections of the Contract. Specifically covered benefits and services are subject to limitations, exclusions, preauthorization and other provisions of this Contract. The exclusions section lists services that are not covered benefits under the Plan. All other benefits and services not listed as covered in this section shall be excluded, except for Clinical Preventative Health Services.

We decide whether a Health Care Service or supply is a specifically covered benefit. When providers prescribe, order, recommend, or approve a Health Care Service or supply it does not guarantee that it is a covered benefit, even if it is not listed as an exclusion.

Medical Necessity
Covered services must be medically necessary, except for Clinical Preventative Care Services. Medical necessity or medically necessary means Health Care Services determined by a provider, in consultation with us, to be appropriate or necessary, according to applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any other applicable clinical protocols or practice guidelines we develop consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral or mental health condition, illness, injury or disease.

Experimental or investigational drugs, medicines, treatments, procedures or devices are not covered with the exception of your clinical trial benefits.

You must get preauthorization in order for some services to be covered services. The Plan will not pay for any of these services without preauthorization. Please read the preauthorization section of this Contract or call Member Services at 1-844-282-3025 for more information about preauthorization.
Please read your *Schedule of Benefits* or call Member Services for more information.

Specific Covered Benefits:
Accidental Injury (Trauma), Urgent Care, Emergency Care Services, and Observation Services
Urgent Care
Urgent Care is medically necessary medical or surgical procedures, treatments, or Health Care Services you get in an urgent care center or in a provider's office for a sudden condition due to illness or injury. Urgent conditions require prompt medical attention to prevent a serious deterioration in your health but do not have to be life threatening.

Contact your Primary Care Physician for an appointment, before getting care from another provider. Preauthorization is required for follow-up care by a non-participating provider. If you think your condition is life threatening, you should seek Emergency Care Services.

Emergency Care Services
We provide coverage for Emergency Care Services 24 hours per day, 7 days per week, when needed. You should seek medical treatment from a participating provider whenever possible. If you cannot reasonably access a participating provider, we will arrange to pay the care at a non-participating provider at the allowable charge for:

- Any medical screening examination or evaluation required by state or federal law to be provided in the emergency facility of a hospital that is needed to decide if an Emergency Medical Condition exists;
- Necessary Emergency Care Services including treatment and stabilization of an Emergency Medical Condition; and
- Services originating in a hospital emergency facility, freestanding emergency medical care facility or comparable emergency facility following treatment or stabilization of an Emergency Medical Condition as authorized by us.

Coverage for trauma services and all other Emergency Care Services will continue at least until you are medically stable, do not require critical care, and can be safely transferred to a participating provider based on the judgment of the attending physician in consultation with us and in accordance with federal law.

We will provide reimbursement when you, acting in good faith, obtain Emergency Care Services for what reasonably appears to be an acute condition that requires immediate medical attention, even if your condition is later determined to not be an emergency.

Preauthorization is not needed for Emergency Care Services. If you are admitted as an inpatient to a hospital, you or your practitioner needs to notify us as soon as possible so we can review your hospital stay. We will approve or deny coverage of post stabilization care as requested by your treating practitioner within the appropriate time, depending on the services requested and your condition, but in no more one hour from the time of the request.

We will not deny a claim for Emergency Care Services when you are sent to the emergency room by your PCP or by our representative. If your Emergency Care Services results in a hospitalization directly from the emergency room, you are responsible for paying the inpatient hospital cost sharing amounts rather than the emergency room visit copayment. Read your *Schedule of Benefits* for the cost sharing amount.

For Emergency Care Services received from a non-participating provider and/or outside of Louisiana, you may seek Emergency Care Services from the nearest appropriate facility where Emergency Care Services can be rendered. Non-emergency follow-up care received outside of Louisiana for your convenience or preference is not a covered benefit.

Follow-up care from a non-participating provider needs preauthorization. You must pay for charges that we do not authorize.

Whether you require hospitalization or not, you should notify your PCP or physician within forty-eight (48) hours, or as soon as reasonably possible, of any emergency medical treatment so they can recommend the continuation of any necessary medical services.

Observation Services
Observation Services are outpatient services provided by a hospital and a provider on the hospital's premises. These services may include the use of a bed and monitoring by a hospital's nursing staff that are reasonable and necessary to evaluate your condition, determine the need for a possible admission to the hospital, or when rapid improvement of the your condition is expected.

When a hospital places you under outpatient observation, it is based upon the provider's written order. To move from observation to an inpatient admission, our level of care criteria must be met.

The length of time spent in the hospital is not the only factor determining observation instead of an inpatient stay. Medical criteria will also be considered.

All accidental injury (trauma), urgent care, emergency care services, and observation services whether provide within or outside of the Plan's service area are subject to the limitations listed in the limitations lection and the exclusions listed in the exclusions section.

Acquired Brain Injury
The Plan covers treatment of an Acquired Brain Injury on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy, and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neuro feedback and remediation therapy, post-acute transition and reintegration services, or other treatment services are covered if such services are medically necessary as a result of and related to an Acquired Brain Injury.

Ambulance Services
The Plan covers the following types of Ambulance Services: (1) Emergency Ambulance Services, (2) High-Risk Ambulance Services, and (3) Inter-facility Transfer services.

Emergency Ambulance Services
Emergency Ambulance Services are ground or air Ambulance Services delivered under reasons that would lead a reasonable and prudent layperson acting in good faith to believe that transportation in any other vehicle would endanger your health. Emergency Ambulance Services are covered only under the following reasons:

- Within Louisiana, to the nearest facility where Emergency Care Services and treatment can be rendered, or to an out-of-network facility if an in-network facility is not reasonably accessible. Such services must be provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside of Louisiana, to the nearest appropriate facility where emergency care services and treatment can be rendered. Such services must be provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- We will not pay more for air Ambulance Services than we would have paid for ground Ambulance services over the same distance unless the service is requested by policing or medical authorities at the site in an emergency situation or if the Member is in a location that cannot be reached by ground ambulance. If the service is requested by policing or medical authorities at the site in an emergency situation or if the Member is in a location that cannot be reached by ground ambulance, payment will be made at the standard out of network rate or at the contracted rate as appropriate.
- In determining whether you acted in good faith as a reasonable and prudent layperson when obtaining Emergency Ambulance Services, we will take the following factors into consideration:
    - Whether you required Emergency Care Services, as defined above
    - Your symptoms
    - Whether a reasonable and prudent layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health
    - Whether you were advised to seek an ambulance service by your practitioner/provider or by our staff. Any such advice will result in reimbursement for all medically necessary services rendered, unless otherwise limited or excluded under this Contract.
    - Ground or air Ambulance Services to any level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

Ambulance Services (ground or air) to the coroner’s office or to a mortuary is not covered, unless the ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncement.

High-Risk Ambulance Services
High-Risk Ambulance Services are defined as non-Emergency Ambulance Services prescribed by your practitioner/provider that are medically necessary for transporting a high-risk patient.

Coverage for High-Risk Ambulance Services is limited to:

- Air ambulance services when medically necessary. However, we will not pay more for air ambulance services than we would have paid for transportation over the same distance by ground ambulance service, unless your condition renders the utilization of such ground ambulance services medically inappropriate.
- Neonatal ambulance services, including ground or air ambulance service to the nearest Tertiary Care Facility when necessary to protect the life of a newborn.
- Ground or air ambulance services to any level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.
- Air or surface ambulance services of a newly born to the nearest available hospital or neonatal special care unit for treatment of illness, injuries, congenital defects, and complications of premature birth. This include the transportation of the temporarily medically disabled mother of the ill newly born, which must be certified by her physician.

Inter-facility Transfer Ambulance Services
Inter-facility Transfer Ambulance Services are defined as ground or air Ambulance Service between hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are covered only if they are:

- Medically necessary
- Prescribed by your practitioner/provider
- Provided by a licensed ambulance service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

Attention Deficit Disorder
Diagnosis and treatment of attention deficit disorder/hyperactivity disorder.

Treatment of Lymphedema
The treatment of lymphedema, rendered or prescribed by a physician licensed in this state or received in any licensed hospital or in any other public or private facility authorized to provide lymphedema treatment, including multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

Cleft Lip/Cleft Palate
Treatment and correction of cleft lip and cleft palate includes coverage for secondary conditions and treatment attributable to primary diagnosis of cleft lip/cleft palate including:

- Oral/facial surgery, management and follow-up
- Prosthetic devices

- Orthodontic treatment and management
- Preventive/restorative dentistry associated with prosthetic and/or orthodontic treatment
- Speech-language evaluation/therapy
- Audiological assessments and amplification devices
- Otolaryngology treatment
- Psychological assessment and counseling
- Genetic Assessment and counseling for patient and parents

Clinical Trials

The Plan provides coverage for medically necessary routine patient care at an in-network facility, incurred as a result of the Member's participation in a clinical trial if:

- The clinical trial has a therapeutic intent, which includes prevention, detection, or treatment of a life-threatening disease or condition;
- The clinical trial is being provided as part of a clinical trial being conducted in accordance with a clinical trial approved or funded by at least one of the following:
    - (a) One of the federal National Institutes of Health, including The Centers for Disease Control and Prevention, The Agency for Health Care Research and Quality, or The Centers for Medicare & Medicaid Services;
    - (b) A federal National Institute of Health Cooperative Group or center;
    - (c) The United States Food and Drug Administration;
    - (d) The United States Department of Veteran Affairs, The United States Department of Defense, or the United States Department of Energy;
    - (e) A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility;
    - (f) An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services;
    - (g) studies or investigations conducted under an investigational new drug application reviewed by the Food and Drug Administration; and
    - (h) studies or investigational drug trial exempt from having such an investigational new drug application under 42 U.S.C. § 300gg-8(d)(1)(C);
- The personnel providing the clinical trial or conducting the study agree to accept reimbursement as payment in full from the Plan and that is not more than the level of reimbursement applicable to other similar services provided by the participating providers within the Plan's network; and agree to provide written notification to the health plan when a patient enters or leaves a clinical trial;
- Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial.

For the purposes of this specific covered benefit and service, the following terms have the following meaning:

- "Routine Patient Care Cost" means

    - (1) A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer or life-threatening Illness treatment; or
    - (2) A drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug.
- Routine Patient Care Cost does not include
    - (1) The cost of an investigational drug, device or procedure;
    - (2) The cost of a non-Health Care Service that the patient is required to receive as a result of participation in the clinical trial;
    - (3) Costs associated with managing the research that is associated with the clinical trial;
    - (4) Costs that would not be covered by the patient if non-investigational treatments were provided; or
    - (5) Costs paid or not charged for by the clinical trial providers.

Certified Hospice Care

This Plan covers Hospice Care Program Services. To be covered, these services must be provided due to terminal illness. These services are limited as stated in your *Schedule of Benefits*. The services must be given under a Hospice Care Program and provided by a licensed and qualified provider. Hospice care services include inpatient care and outpatient services. Also included are the professional services of a physician. Other covered services include those of a psychologist, social worker or family counselor. The following services are not covered by the Plan:

- Services provided by a family member or someone who usually lives in your home or your Dependent's home,
- Services or supplies not listed in the Hospice Care Program,
- Curative or life prolonging procedures,
- Services for which any other benefits are payable under the Plan,
- Services or supplies that are primarily to aid in daily living,
- Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals; or
- Respite care.

Preventative Care Services

The Plan covers primary care and specialist services for preventative care and periodic health exams. Although preventative care is covered at no charge, an office visit copay may apply for other covered services provided during your visit. The Plan also covers all essential health benefits, including those listed in this Contract. There is no cost sharing for essential health benefit preventative care services.

Preventative Care Services have been determined based on the current recommendations of the United States Preventative Services Task Force (USPTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP), and the Health Resources and Services Administration (HRSA).

Preventative Services for Cancer Screening
The Plan covers genetic or molecular cancer testing including but not limited to traditional whole genome sequencing, rapid whole genome sequencing, and other genetic and genomic screening that include individual sequencing, trio sequencing for a parent or parents of the infant, and ultra-rapid sequencing for an infant who is one year of age or younger, is receiving inpatient hospital services in an intensive care unit or in a pediatric care unit, and has a complex illness of unknown etiology, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomic testing, whole exome, genome sequencing and biomarker testing. Coverage is subject to annual deductibles, coinsurance, copayment provisions and is subject to applicable evidence-based medical necessity criteria.

Preventative Services for Adult Members:

- Abdominal aortic aneurysm screening with ultrasonography in men aged sixty-five (65) to seventy-five (75) years who have ever smoked (one time screening);
- Alcohol misuse screening and counseling;
- Aspirin use for Members of certain ages;
- Blood pressure screening;
- Cholesterol screening for Members of certain ages or at higher risk;
- Colorectal cancer screening for Members beginning at age forty-five (45) including a colonoscopy every ten (10) years; annual Fecal Immunochemical Test (FIT) for blood; or Flexible Sigmoidoscopy every five (5) to ten (10) years, CT colonography every five (5) years or the FIT-fecal DNA test every three (3) years or capsule colonoscopy every five (5) years;
- Depression screening;
- Lung cancer screening;
- Type 2 Diabetes screening for Members with high blood pressure;
- Diet counseling for Members at higher risk for chronic disease;
- HIV screening for all Members at higher risk;
- Hepatitis C virus infection screening;
- Immunization vaccines – doses, recommended ages and recommended populations can vary;
- Obesity screening and counseling;
- Sexually Transmitted Infection (STI) prevention counseling for Members at higher risk;
- Tobacco use screening for all Members and cessation interventions for tobacco users, including expanded counseling for pregnant tobacco users;
- Syphilis screening for all adults at higher risk;
- Fall prevention in older adults, including exercise or physical therapy and Vitamin D;
- Skin cancer behavioral counseling;

- Hepatitis B Screening;
- Tuberculosis Screening;
- Statin preventive medication: adults ages forty (40) to seventy-five (75) years with no history of CVD, one or more CVD risk factors, and a calculated ten (10) year CVD event risk of 10% or greater.

Additional Preventative Services include but are not limited to:

- Annual physical examinations, one per calendar year;
- Educational materials or consultations from providers to promote healthy living;
- Periodic glaucoma eye tests for all Members thirty-five (35) years of age or older;
- Periodic laboratory screening tests, including tests that determine metabolic, blood hemoglobin, blood glucose level, and blood cholesterol level; and
- Periodic radiological screening tests;
- Over the counter medications and drugs prescribed by a practitioner/provider;
- Noninvasive screening tests for atherosclerosis and abnormal artery structure and function for Members who are diabetic or have a risk of developing heart disease and are:
    - Men between the age of forty-five (45) and seventy-six (76), and
    - Women between the age of fifty-five (55) and seventy-six (76).

Preventative Services Specifically for Women:

- Routine anemia screening
- Bacteriuria urinary tract or other infection screening;
- Breastfeeding comprehensive support, supplies and counseling;
- Folic acid supplements for Members who may become pregnant;
- Preeclampsia prevention;
- Hepatitis B screening for pregnant Members at their first prenatal visit;
- Osteoporosis screening; and
- RH incompatibility screening and follow-up testing for Members at higher risk.
- Anxiety screening in adolescent and adult women, including those who are pregnant or postpartum as recommended by The Women's Preventative Services Initiative (HRSA).

Preventative Services for Children:

- Well baby and well childcare from birth in accordance with recommendations of the American Academy of Pediatrics;
- Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum;
- Alcohol and drug use assessments for adolescents;
- Autism screening for children at 0-24 months.;
- Behavioral assessments for children of all ages;
- Blood pressure screening;
- Cervical dysplasia screening for sexually active females;
- Congenital hypothyroidism screening for newborns;

- Depression screening for adolescents;
- Developmental screening for children under age three (3) and surveillance throughout childhood;
- Dyslipidemia screening for children at higher risk of lipid disorders;
- Fluoride chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns up to Members age seventeen (17);
- Height, weight and body mass index measurements for children;
- Hematocrit or hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- Hepatitis B screening;
- HIV screening for adolescents at higher risk;
- Immunization vaccines for children from birth to age eighteen (18) – doses, recommended ages and recommended populations vary;
- Iron supplements for children ages six (6) to twelve (12) months at risk for anemia;
- Lead screening for children at risk of exposure;
- Medical history for all children throughout development;
- Obesity screening and counseling;
- Oral health risk assessment for young children (newborns to children age ten (10));
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tobacco use interventions;
- Tuberculin testing for children at higher risk of tuberculosis;
- Vision screening for all children;
- Educational materials or consultations from providers to promote a healthy lifestyle; and
- Habilitative therapies for children with developmental delay as specified by an Early Childhood Intervention individualized family service plan.

Complementary Therapies

Chiropractic Services

Chiropractic Services are available based on medical necessity and in conjunction with a chiropractor licensed in this state. They are not available for maintenance therapy such as routine adjustments. Chiropractic Services are subject to the following:

- Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. We do not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment.

Biofeedback is only covered for treatment of Raynaud’s disease or phenomenon and urinary or fecal incontinence.

Dental Services (Limited)
Your plan includes a network of contracted dentists for you to access for your dental needs. We do not deny any dentist the right to participate as a contracting provider or authorize any person to regulate, interfere, or intervene in the diagnosis or treatment provided by a participating dentist.

We do not require that the dentist make or obtain dental x-rays or any other diagnostic aids; however, they still may be requested in order to determine benefits payable.

The dentists participating in the network are reimbursed based on usual, customary, and reasonable fees, where providers are reimbursed based on what dentists in the area usually charge for the same or similar service. If services are required from a noncontracting dentist when a participating provider is not available within the service area, the payment will be the same or greater than what would be received by a participating dentist but not to exceed the fee charged by the dentist for the dental service rendered.

Routine Dental Services may be covered for children only. Covered services under this Contract include, but are not limited to:

- Services to diagnose or to prevent tooth decay and other forms of oral disease.
    - Oral exams (once every six months)
    - Bitewings (once every six months)
    - Panoramic films (once every six months)
    - Topical application of fluoride
    - Tooth sealants
    - Space maintainer
- Services to treat oral disease, including services to:
    - Restore decayed or fractured teeth
    - Repair dentures or bridges
    - Rebase or reline dentures
    - Repair or recement bridges, crowns, and onlays
    - Remove diseased or damaged natural teeth
- Service and supplies to treat oral disease including services to:
    - Replace missing natural teeth with artificial ones,
    - Remove diseased or damaged natural teeth
    - Restore severely decayed or fractured teeth
- Medically Necessary Orthodontics
- Anesthesia for medically covered dental services provided in a hospital setting and for associated hospital charges when the mental or physical condition of the insured requires dental treatment to be rendered in a hospital setting.

Dental services related to accidental injury are covered services regardless of age.

This is not an all-inclusive list of benefits and the required FEDVIP dental benefits are provided to children until age nineteen (19).

Delta Dental's Louisiana Pediatric AIAN Plan Offered with CHRISTUS' Louisiana Pediatric and Family AIAN Plan

Deductibles & Maximums		
	PPO Provider	**Delta Dental Premier or Non-Delta Dental Provider**
Annual Deductible Pediatric Member	No Deductible	
Out-of-Pocket Maximum* Pediatric Member Multiple Pediatric Enrollees	Dental annual out-of-pocket maximum accumulates toward the medical out of pocket maximum. Refer to Christus Schedule of Benefits for out-of-pocket maximum amounts	

Contract Benefit Levels & Member Coinsurances				
Dental Service Category	**PPO**[1]			
	Delta Dental		**Enrollee**	
	PPO Provider	**Delta Dental Premier or Non-Delta Dental Provider**	**PPO Provider**	**Delta Dental Premier or Non-Delta Dental Provider**
Diagnostic and Preventive Services	100%		0%	
Basic Services	100%		0%	
Major Services	100%		0%	
Medically Necessary Orthodontic Services (requires prior authorization)	100%		0%	
Waiting Periods	No Waiting Periods		No Waiting Periods	

Delta Dental's Louisiana Pediatric High Plan Offered with all of CHRISTUS' Bronze Plans, Silver Plans, Standard Gold Plan, and Gold Plan

Deductibles & Maximums		
	PPO Provider	Delta Dental Premier or Non-Delta Dental Provider
Annual Deductible Pediatric Member	No Deductible	
Out-of-Pocket Maximum* Pediatric Member Multiple Pediatric Members	Dental annual out-of-pocket maximum accumulates toward the medical out of pocket maximum. Refer to Christus Schedule of Benefits for out-of-pocket maximum amounts.	

Contract Benefit Levels & Member Coinsurances				
Dental Service Category	**Delta Dental PPO**[1]			
	Delta Dental[2]		**Enrollee**[2]	
	PPO Provider	**Delta Dental Premier or Non-Delta Dental**	**PPO Provider**	**Delta Dental Premier or Non-Delta Dental**
Diagnostic and Preventive Services	100%		0%	
Basic Services	80%		20%	
Major Services	50%		50%	
Medically Necessary Orthodontic Services **(requires prior authorization)**	50%		50%	
Waiting Periods	No Waiting Periods		No Waiting Periods	

Delta Dental's Louisiana Family High Plan
Offered with CHRISTUS' Bronze Plus, Bronze Essential Plus, Silver Plus, Silver Essential Plus, Gold Plus, Gold Essential Plus

Deductibles & Maximums		
	Adult Benefits (age 19 and older)	**Pediatric Benefits (under age 19)**
Annual Deductible Member Family (three or more Enrollees)	No Deductible	
Annual Maximum Member	$1,000	
Out-of-Pocket Maximum* Pediatric Member Multiple Pediatric Member	Dental annual out-of-pocket maximum accumulates toward the medical out of pocket maximum. Refer to Christus Schedule of Benefits for out-of-pocket maximum amounts.	

Contract Benefit Levels &Member Coinsurances				
	Adult Benefits (age 19 and older)		**Pediatric Benefits (under age 19)**	
Dental Service Category	**Delta Dental PPO**[1]		**Delta Dental PPO**[1]	
	Delta Dental[2]	Enrollee[2]	Delta Dental[2]	Enrollee[2]
Diagnostic and Preventive Services	100%	0%	100%	0%
Basic Services	80%	20%	80%	20%
Major Services	50%	50%	50%	50%

Medically Necessary Orthodontic Services **(Requires prior authorization)**	Not a covered benefit	Not a covered benefit	50%	50%
Waiting Periods	Major Services are limited to Adult Members who have been enrolled under this Contract for 12 consecutive months.[3]		No Waiting Periods	

Reimbursement is based on Delta Dental PPO Contracted Fees for Delta Dental PPO, Delta Dental Premier and Non-Delta Dental Providers.

[2] Delta Dental will pay or otherwise discharge the Contract benefit level according to the Maximum Contract Allowance for covered services. Note: Delta Dental will pay the same Contract benefit level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider. However, the amount charged to Members for covered services performed by a premier provider or Non-Delta Dental provider may be above that accepted by PPO providers, and e Members will be responsible for balance billed amounts.

[3] Waiting Periods are calculated for each adult Members from the effective date of coverage reported by the exchange for said adult Member. Prior coverage for adult Members under any Delta Dental Exchange plan that included an adult waiting period will be credited towards the adult waiting period under this dental plan. In order for prior coverage to be credited, such prior coverage must occur immediately preceding the election of this plan.

Out-of-pocket maximum applies only to essential health benefits that are provided by Delta Dental PPO Providers for pediatric Members. Once the amount paid by pediatric Member (s) equals the out-of-pocket maximum, no further payment will be required by the Pediatric Member(s) for the remainder of the calendar year for covered services received from Delta Dental PPO providers. Member coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Delta Dental Premier or Non-Delta Dental providers even after the out-of-pocket maximum is met.

If two or more pediatric Members are covered, the financial obligation for covered services received from Delta Dental PPO providers is not more than the multiple pediatric Members out-of-pocket maximum. However, once a pediatric Member meets the out-of-pocket maximum for one covered pediatric Member, that pediatric Member will have satisfied their out-of-pocket maximum. Other covered pediatric enrollees must continue to pay Member coinsurance for covered services received from Delta Dental PPO providers until the total amount paid reaches the out-of-pocket maximum for multiple pediatric Members.

Attachment B

Services, Limitations and Exclusions

Description of Dental Services for Adult Benefits (Age 19 and Older)

We will pay or otherwise discharge the Contract benefit level shown in attachment A for the following services:

- **Diagnostic and Preventive Services**

(1)	Diagnostic:	Procedures to aid the provider in determining required dental treatment.
(2)	Preventive:	Cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth (periodontal maintenance is considered to be a basic service for payment purposes).
(3)	Specialist Consultations:	Opinion or advice requested by a general dentist.

- **Basic Services**

(1)	General Anesthesia or IV Sedation:	When administered by a provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
(2)	Periodontal	Periodontal maintenance.
(3)	Palliative:	Emergency treatment to relieve pain.
(4)	Restorative:	Amalgam and resin-based composite restorations (fillings) and prefabricated restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Major Services**

(1)	Crowns and Inlays/Onlays:	Treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.

(2)	Prosthodontics:	Procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
(3)	Oral Surgery:	Extractions and certain other surgical procedures (including pre-and post-operative care).
(4)	Endodontics:	Treatment of diseases and injuries of the tooth pulp.
(5)	Periodontics:	Treatment of gums and bones supporting teeth.
(6)	Denture Repairs:	Repair to partial or complete dentures, including rebase procedures and relining.

- **Note on additional benefits during pregnancy**

When a Member is pregnant, we will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services each calendar year while the Member is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Member or the Member's Provider when the claim is submitted.

- **Teledentistry Services**

Teledentistry services are dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification.
Teledentistry services use telecommunications and information technology to deliver the services to a Member in one physical location while the dentist or health professional is located in a different physical location.

Limitations for Adult Benefits (Age 19 and Older)

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

a) A composite restoration instead of an amalgam restoration on posterior teeth;

b) A crown where a filling would restore the tooth;

c) An inlay/onlay instead of an amalgam restoration; or

d) Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

If a Member receives optional services, an alternate benefit will be allowed, which means we will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service. The Member will be responsible for the difference between the higher cost of the optional service and the lower cost of the customary service or standard procedure.

(2) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(3) We will pay for oral examinations (except after hours exams and exams for observation) no more than twice in a calendar year.

(4) We will pay for cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than twice in a calendar year. A full mouth debridement is allowed once in a lifetime, when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided. Note that periodontal maintenance, procedure codes that include periodontal maintenance, and full mouth debridement are covered as a basic benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a diagnostic and preventive benefit. See note on additional benefits during pregnancy.

(5) A caries risk assessment is allowed once in twelve (12) months.

(6) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(7) Application of caries arresting medicament is limited to twice per tooth per calendar year.

(8) X-ray limitations:

a) We will limit the total reimbursable amount to the provider’s accepted fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the accepted fee for a complete intraoral series.

b) When a panoramic film is submitted with supplemental film(s), we will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series.

c) If a panoramic film is taken in conjunction with an intraoral complete series, we consider the panoramic film to be included in the complete series.

d) A complete intraoral series and panoramic film are each limited to once every sixty (60) months.

e) Bitewing x-rays are limited to one (1) time each calendar year. Bitewings of any type are not billable to the Member or Us within twelve (12) months of a full mouth series unless warranted by special circumstances.

f) Image capture procedures are not separately allowable services.

(9) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(10) Specialist consultations are limited to once per lifetime per provider and count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a twelve (12)-month period and included if reported, with any other examination on the same date of service and provider office.

(11) We will not cover to replace amalgam and resin-based composite restorations (fillings) and prefabricated restorations within twenty-four (24) months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations, including reattachment of a tooth fragment, within twenty-four (24) months are included in the fee for the original restoration.

(12) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(13) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.

(14) Pulpal debridement and partial pulpotomy for apexogenesis are limited to once per lifetime.

(15) Pulpal therapy (resorbable filling) is limited to once in a lifetime. Retreatment of root canal therapy by the same provider/provider office within twenty-four (24) months is considered part of the original procedure.

(16) Hemisection (including any root removal), not including root canal therapy, root amputation per root, internal root repair of perforation defects and incomplete

endodontic therapy; inoperable, unrestorable or fractured tooth, are limited to once in a lifetime.

(17) Retreatment of apical surgery by the same provider/provider office within twenty-four (24) months is considered part of the original procedure.

(18) Pin retention is covered not more than once in any twenty-four (24)-month period.

(19) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select diagnostic procedures.

(20) Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every twenty-four (24)-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional benefits during pregnancy.

b) Periodontal surgery in the same quadrant is limited to once in every thirty-six (36)-month period and includes any surgical re-entry or scaling and root planing performed within thirty-six (36) months by the same dentist/dental office. Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

c) Guided tissue regeneration and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.

d) Periodontal surgery is subject to a thirty (30)- day wait following periodontal scaling and root planing in the same quadrant.

e) Cleanings (regular and periodontal) and full mouth debridement are subject to a thirty (30)-day wait following periodontal scaling and root planing if performed by the same provider office.

f) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surface, without flap entry and closure is covered as a basic benefit and are limited to once in a twenty-four (24)-month period.

(21) Oral surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.

(22) Oral surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.

(23) General anesthesia, intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.

(24) Crowns and inlays/onlays are covered not more often than once in any sixty (60)-month period except when we determine the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(25) Core buildup, including any pins, is covered not more than once in any sixty (60)-month period.

(26) Post and core services are covered not more than once in any sixty (60)-month period.

(27) When allowed within six (6) months of a restoration, the benefit for a crown, inlay/onlay or fixed prosthodontic service will be reduced by the benefit paid for the restoration.

(28) Denture repairs are covered not more than once in any six (6) month period except for fixed Denture repairs which are covered not more than once in any sixty (60)-month period.

(29) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after sixty (60) months have passed, except when we determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if we determine it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant in sixty (60) months whether provided under Delta Dental or any other dental care plan. Implant/abutment supported removable dentures and fixed dentures will receive a benefit allowance for the corresponding conventional removable appliances. The Member is responsible for the difference in the fee for an implant/abutment supported denture and the fee for a conventional prosthodontic appliance.

(30) Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments, are covered once in thirty-six (36) months.

(31) Oral surgery services are covered once in a lifetime except removal of benign odontogenic cysts or tumors, excision of benign lesions and incision and drainage procedures, which are covered once in the same day.

(32) General anesthesia, intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures.

(33) Recementation of crowns, inlays/onlays, indirectly fabricated or prefabricated post and core, or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same provider/provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(34) The initial installation of a prosthodontic appliance and/or implants is not a benefit unless the
prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Member was under a Delta Dental plan.

(35) Occlusal adjustment - limited, is allowed once in a sixty (60)-month period.

(36) We limit payment for dentures to a standard partial or complete denture (Membercoinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.

a) Denture rebase is limited to one (1) per arch in a twenty-four (24)-month period and includes any relining and adjustments for six (6) months following placement.

b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a calendar year and relining is limited to one (1) per arch in a six (6) month period.

c) Tissue conditioning is limited to two (2) per arch in a twelve (12)-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.

d) Recementation of fixed partial dentures is limited to once in a lifetime.

(37) Frenulectomy is only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician, or if there is a papilla penetrating frenum interfering with closure of a diastema.

Exclusions for Adult Benefits (Age 19 and Older)

We do not pay Benefits for:

(1) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) Cosmetic surgery or procedures for purely cosmetic reasons.

(3) Maxillofacial prosthetics.

(4) Provisional and/or temporary restorations.

(5) Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or night guards/occlusal guards and abfraction.

(7) Any single Procedure provided prior to the date the Member became eligible for services under this plan.

(8) Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) Charges for anesthesia, other than general anesthesia and IV sedation administered by a provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.

(10) Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) Interim implants.

(12) Indirectly fabricated resin-based inlays/onlays.

(13) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(14) Teatment by someone other than a provider or a person who by law may work under a Provider's direct supervision.

(15) Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(16) Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(17) Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(18) Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Member and not a covered Benefit.

(19) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(20) Services covered under the dental plan but exceed benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(21) The initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Member is covered under the Contract or was covered under any dental care plan with Delta Dental. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(22) Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(23) Services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(24) Endodontic endosseous implants.

(25) Services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.

(26) Missed and/or cancelled appointments.

(27) Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(28) The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(29) Dental case management motivational interviewing and patient education to improve oral health literacy.

(30) Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(31) Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(32) Diabetes testing.

(33) Corticotomy (specialized oral surgery procedure associated with orthodontics).

(34) Antigen or antibody testing.

(35) Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Description of Dental Services for Pediatric Benefits (Under Age 19)

We will pay or otherwise discharge the Contract benefit level shown in attachment a for essential health benefits when provided by a provider and when necessary and customary under generally accepted dental practice standards and for medically necessary orthodontic services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

(1)	Diagnostic:	Procedures to aid the Provider in determining required dental treatment.
(2)	Preventive:	Cleanings, including scaling in presence of generalized moderate or severe gingival inflammation - full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.

(3) Sealants:	Topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
(4) Specialist Consultations:	Opinion or advice requested by a general dentist.

- **Basic Services**

(1) General Anesthesia or IV Sedation:	When administered by a provider for covered oral surgery or selected endodontic and periodontal surgical procedures.
(2) Periodontal Cleanings:	Periodontal maintenance.
(3) Palliative:	Emergency treatment to relieve pain.
(4) Restorative:	Amalgam and resin-based composite restorations (fillings) and prefabricated stainless-steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

- **Major Services**

(1) Crowns and Onlays/Inlays:	Treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
(2) Prosthodontics:	Procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
(3) Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
(4) Endodontics:	treatment of diseases and injuries of the tooth pulp.
(5) Periodontics:	treatment of gums and bones supporting teeth.
(6) Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.
(7) Night Guards/Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits.

- **Note on additional benefits during pregnancy**

When a Member is pregnant, we will pay for additional services to help improve the oral health of the Member during the pregnancy. The additional services each calendar year while the Member is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of

the pregnancy must be provided by the Member or the Member's provider when the claim is submitted.

- **Teledentistry Services**

Teledentistry services are dental services delivered by a dentist acting within the scope of the dentist's license, or by a health professional acting under the dentist's delegation and supervision and within the scope of the health professional's license or certification.

Teledentistry services use telecommunications and information technology to deliver the services to a Member E in one physical location while the dentist or health professional is located in a different physical location.

We cover teledentistry services the same as services provided in an in-office visit.

Limitations for Pediatric Benefits (Under Age 19)

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional services also include the use of specialized techniques instead of standard procedures.

If a Member receives optional services, an alternate benefit will be allowed, which means We will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service. The Member will be responsible for the difference between the higher cost of the optional service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, we shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Exam and cleaning limitations:

a) We will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized

moderate or severe gingival inflammation (or any combination thereof) no more than once every six (6)

b) A full mouth debridement is allowed once in a lifetime, when the Member has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.

c) Note that periodontal maintenance, procedure codes that include periodontal maintenance, and full mouth debridement are covered as a basic benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a diagnostic and preventive benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

d) Caries risk assessments are allowed once in twelve (12) months.

e) Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

(5) Application of caries arresting medicament is limited to twice per tooth per calendar year.

(6) X-ray limitations:

a) We will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the accepted fee for a complete intraoral series.

b) When a panoramic film is submitted with supplemental film(s), we will limit the total reimbursable amount to the provider's accepted fee for a complete intraoral series.

c) If a panoramic film is taken in conjunction with an intraoral complete series, we consider the panoramic film to be included in the complete series.

d) A complete intraoral series and panoramic film are each limited to once every sixty (60) months.

e) Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are not billable to the Member or us within twelve (12) months of a full mouth series unless warranted by special circumstances.

f) Image capture procedures are not separately allowable services.

(7) The fee for pulp vitality tests are included in the fee for any definitive treatment performed on the same date.

(8) Topical application of fluoride solutions is limited to twice within a twelve (12)-month period.

(9) A distal shoe space maintainer - fixed - unilateral is limited to children eight (8) and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different provider/provider's office.

(10) Sealants are limited as follows:

a) Once in 36 months to permanent molars if they are without caries (decay) or restorations on the occlusal surface.

b) Repair or replacement of a Sealant on any tooth within twenty-four (24) months of its application is included in the fee for the original placement.

(11) Preventive resin restorations in a moderate to high-risk caries risk patient – permanent tooth are limited to once per tooth in thirty-six (36) months.

(12) Specialist Consultations count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a twelve (12)- month period and included if reported, with any other examination on the same date of service and Provider office.

(13) We will not cover replacement of an amalgam or resin-based composite restorations (fillings) within twenty-four (24) months of treatment if the service is provided by the same Provider/Provider office. Prefabricated crowns are limited to once per Member per tooth in any sixty (60)-month period. Replacement restorations within twenty-four (24) months are included in the fee for the original restoration.

(14) Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations is included in the fee for any definitive treatment performed on the same date.

(15) Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth through age fourteen (14). Replacement restorations within twenty-four (24) months are included in the fee for the original restoration.

(16) Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.

(17) Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Members up to age six (6) and for primary molars and cuspids up to age eleven (11). Retreatment of root canal therapy by the same provider/provider office within twenty-four (24) months is considered part of the original procedure.

(18) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.

(19) Retreatment of apical surgery by the same provider/provider office within twenty-four (24) months is considered part of the original procedure.

(20) Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

(21) Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select diagnostic procedures is considered included in the fee for the definitive treatment.

(22) Periodontal limitations:

a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every twenty-four (24)-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional benefits during pregnancy.

b) Periodontal surgery in the same quadrant is limited to once in every thirty-six (36)-month period and includes any surgical re-entry or scaling and root planing performed within thirty-six (36) months by the same dentist/dental office.

c) Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d) Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.

e) Periodontal surgery is subject to a thirty (30) day wait following periodontal scaling and root planing in the same quadrant.

f) Cleanings (regular and periodontal) and full mouth debridement are subject to a thirty (30) day wait following periodontal scaling and root planing if performed by the same Provider office.

g) When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a twenty-four (24)-month period.

(23) Collection and application of autologous blood concentrate product are limited to once every 36 months.

(24) Crowns and Inlays/Onlays are covered not more often than once in any 60-month period except when We determine the existing Crown or Inlay/Onlay is not satisfactory

and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.

(25) Core buildup, including any pins, is covered not more than once in any 60-month period.

(26) Prefabricated post and core, in addition to crown is covered once per tooth every 60-month period.

(27) Resin infiltration of incipient smooth surface lesions is covered once in any 36-month period.

(28) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(29) Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if we determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Our payment for implant removal is limited to one (1) for each implant within a 60-month period whether provided under Delta Dental or any other dental care plan.

(30) Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.

(31) An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.

(32) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a benefit.

(33) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown,Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.

(34) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Member was under a Delta Dental plan.

(35) We limit payment for dentures to a standard partial or complete denture (Member Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.

a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.

b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining is limited to one (1) per arch in a 36-month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a 36-month period.

c) Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline or rebase service.

(36) Occlusal guards are covered by report for Members age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. We will not cover the repair or replacement of any appliances for Night Guard/Occlusal Guard. Adjustment of an occlusal guard is allowed once in 12 months following six months from initial placement.

(37) Limitations on Orthodontic Services:

a) Services are limited to medically necessary orthodontics when provided by a Provider. Orthodontic treatment is a Benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.

b) Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.

c) The automatic qualifying conditions are:

i) Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be

submitted, on their professional letterhead, with the prior authorization request,

ii) A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

iii) A crossbite of individual anterior teeth causing destruction of soft tissue,

iv) Severe traumatic deviation.

d) The following documentation must be submitted with the request for prior authorization of services by the Provider:

i) ADA 2006 or newer claim form with service code(s) requested;

ii) Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;

iii) Cephalometric radiographic image or panoramic radiographic image;

iv) HLD score sheet completed and signed by the Orthodontist; and

v) Treatment plan.

e) The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Member is permitted.

f) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.

g) Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Members under the age of 19 and shall be prior authorized.

h) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Member is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a Benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

i) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

j) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, we will make an allowance for the cost of a standard orthodontic treatment. The Member is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist’s charge for the specialized orthodontic appliance or procedure.

k) Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.

l) Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered (or any type of "do it yourself") orthodontics are not covered.

m) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

Exclusions for Pediatric Benefits (Under Age 19)

We do not pay benefits for:

(1) Services that are not essential health benefits.

(2) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) Cosmetic surgery or procedures for purely cosmetic reasons.

(4) Maxillofacial prosthetics.

(5) Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

(6) Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) Any single procedure provided prior to the date the Member became eligible for services under this plan.

(9) Prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

(11) Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) Laboratory processed crowns for teeth that are not developmentally mature.

(13) Endodontic endosseous implants.

(14) Indirectly fabricated resin-based inlays/onlays.

(15) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(16) Treatment by someone other than a provider or a person who by law may work under a Provider's direct supervision.

(17) Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(18) Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.

(19) Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(20) Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under the Contract, will be the responsibility of the enrollee and not a covered benefit.

(21) Deductibles and/or any service not covered under the dental plan.

(22) Services covered under the dental plan but exceed benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(23) The initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the enrollee is covered under the Contract or was covered under any dental care plan with Delta Dental. The extraction of a third molar (wisdom tooth) will not qualify

under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(24) Services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(25) Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided a prior authorization is obtained.

(26) Missed and/or cancelled appointments.

(27) Actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

(28) The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

(29) Dental case management motivational interviewing and patient education to improve oral health literacy.

(30) Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

(31) Extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

(32) Diabetes testing.

(33) Corticotomy (specialized oral surgery procedure associated with orthodontics).

(34) Antigen or antibody testing.

(35) Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Diabetes Services

When used to treat insulin dependent diabetes, non-insulin dependent diabetes, or high blood glucose levels induced by pregnancy, the Plan will cover the following medically necessary services and supplies which shall be subject to the same annual deductibles or co-insurance for all other covered benefits:

- Blood glucose monitors, including those for the legally blind, and test strips;
- Glucagon emergency kits;
- Insulin, insulin analogs, insulin pumps and associated appurtenances;
- Prescriptive oral agents and non-prescriptive oral agents for controlling blood sugar levels;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Lancet and lancet devices;

- Podiatric appliances for the prevention of foot complications, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment;
- Physician visits and post-diagnosis follow-up care;
- Self-management training, including medical nutritional therapy related to diabetes management; medically necessary visits upon diagnosis of diabetes; visits following a physician diagnosis that represents a significant change in patient; and visits for reeducation;
- Syringes; and
- Visual reading urine and ketone strips.

Contact Member Services for questions regarding these requirements at 1-844-282-3025.

The Plan will evaluate if changes to the *Formulary* or Contract are needed when new or improved equipment is approved by the Food and Drug Administration (FDA). This may include new or improved appliances, prescription drugs, insulin, or diabetic supplies. Contact the Plan or visit our website www.christushealthplan.org for up-to-date information.

Diagnostic Services
Laboratory, x-ray and other diagnostic tests are a covered service when medically necessary and provided under the direction of your provider; including, but not limited to:

- Blood tests;
- Urinalysis;
- Pathology tests;
- Sleep studies performed in the home or in a sleep lab that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM);
- X-rays, ultrasounds, and other imaging studies;
- Electrocardiograms (EKGs), Electroencephalograms (EEGs), and other electronic diagnostic procedures; and
- CT scans; PET scans; MRIs; and CT colonoscopies (virtual colonoscopies).

Some Diagnostic Services require preauthorization. Refer to the preauthorization section for more information.

Biomarker Testing

Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an individual's disease or condition when the test provides clinical utility as demonstrated by medical and scientific evidence, including any one of the following items:

- Labeled indications for diagnostic tests approved or cleared by the United States Food and Drug Administration or indicated diagnostic tests for a drug approved by the United States Food and Drug Administration.

- Warnings and precautions listed on a United States Food and Drug Administration approved drug label.
- National Coverage Determinations of the Centers for Medicare and Medicaid Services or Local Coverage Determinations of Medicare Administrative Contractors.
- Nationally recognized clinical practice guidelines.

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices and Hearing Aids

Disposable Medical Equipment
Disposable medical equipment or supplies (excluding glucometer, diabetic strips and lancets) related to and necessary for the administration of prescription drugs, such as syringes and needles, and other disposable medical equipment or supplies which have a primary medical purpose are covered and will be subject to reasonable quantity limits as determined by the Plan.

Durable Medical Equipment
DME is a covered service when it is medically necessary and preauthorized by the Plan. Equipment must be necessary for a person's case or health status.

Coverage includes the rental or purchase of DME, at our option. Examples of DME include, but are not limited to:
- Crutches;
- Hospital beds;
- Oxygen equipment;
- Wheelchairs; and
- Walkers.

In addition to being medically necessary and preauthorized by the Plan, durable medical equipment should meet the following criteria:
- Be able to withstand repeated use;
- Be reusable by other people;
- Be used to serve a medical purpose; and
- The equipment is generally not useful to a person who is not ill or injured.

There are some exclusions and limitations to DME coverage:
- DME coverage is for medically appropriate equipment only, and does not include special features, upgrades or equipment accessories unless medically necessary.
- The Plan will cover the rental or purchase of medically necessary DME, including repair and adjustment of DME. We will not cover repairs that exceed the purchase price.
- Repair or replacement of DME is covered if it is medically necessary, as determined by us, or due to a change in the Member's physical or medical condition. Repair of DME or

prosthetic or orthotic devices which were previously owned by the Member and not supplied to them through the Plan may be covered, except as defined under diabetes supplies and treatment. Coverage for these repairs shall be at our discretion.

- The Plan follows guidelines established by Medicare for the lifetime of DME. Equipment is expected to last at least five (5) years;
- Replacement due to loss, theft, misuse, abuse, or destruction is not covered. The Plan also will not cover replacement in cases where the patient improperly sells or gives away the equipment;
- The Plan does not cover replacement of DME solely for warranty expiration, or new improved equipment becoming available. The Plan does not cover duplicate or extra DME for the purpose of Member comfort, convenience or travel.

Orthotic Appliances

Orthotic Appliances are covered when medically necessary. Orthotic appliances include braces and other external devices used to correct a bodily function including clubfoot deformity. Orthotic appliances are subject to the following limitations:

- Foot orthotics or shoe appliances are not covered, except for our Members with diabetic neuropathy or other significant neuropathy. Custom fabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are covered for our Members in accordance with nationally recognized guidelines.

Prosthetic Devices

Internal prosthetics and/or medical appliances and services as well as any necessary clinical care and both limb and non-limb devices are covered when ordered by a physician and preauthorized by us. A Member may choose a prosthetic device that is priced higher than the benefit payable and may pay the difference between the price of the device and the benefit payable, without financial or contractual penalty to the provider.

An External Prosthetic Appliance (EPA) is covered with preauthorization and edically necessary for a person's case or health status. External prosthetic appliances are artificial substitutes worn on, or attached to the outside of the body; are used to replace a missing part (such as the leg, arm, or hand); or are needed to alleviate or correct an illness, injury, or congenital defect. We will cover EPA that is necessary to accomplish ordinary activities of daily living. Braces are considered EPA. (This does not include orthodontic braces.)

There are some exclusions and limitations that apply to coverage for EPA:

- This Plan will cover replacement of EPA if it is needed due to normal body growth or for changes due to illness or injury.
- We follow Medicare guidelines to determine the lifetime of EPA.
- The Plan covers pre-fabricated EPA unless there is clinical documentation supporting that custom EPA is medically necessary. This includes upgrades or accessories that do not serve a therapeutic purpose.

- EPA for the purpose of being able to participate in recreational or leisure activities is not covered.
- EPA for the purpose of being able to play a sport is not covered.
- Repair or replacement of EPA is covered if it is medically necessary as determined by the Plan.
- Repair or replacement of EPA is not covered if due to loss, theft or destruction.
- The Plan does not cover duplicate or extra EPA for your convenience or comfort.

Implanted Medical Devices
The Plan covers implanted medical devices when medically necessary and ordered by a participating provider. These devices include but are not limited to pacemakers, artificial hip joints, cochlear implants, and cardiac stents. Coverage consists of permanent or temporary internal aids and supports for defective body parts. We will also cover the cost for repairs or maintenance of covered appliances. Services require preauthorization; refer to the preauthorization section for more information.

Hearing Aids
The Plan covers hearing aids and certain related services. Services include fitting and dispensing fees; and ear molds, as necessary, to maintain optimal fit of the hearing aids; any treatment relating to hearing aids, including coverage for habilitation and rehabilitation as necessary for educational gain. Hearing aid means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills. Services must be provided by an audiologist, hearing aid dispenser or physician. This benefit is limited to one hearing aid in each ear every three (3) years.

Medically or audiologically necessary cochlear implants for each ear with internal replacement are covered under this Plan. Services include fitting and dispensing services, treatment for habilitation and rehabilitation, and external speech processor and controller with necessary component and replacement every three years.

Members of all ages have the option to choose a hearing aid priced higher than the benefit set by the Plan at a higher price. Any difference over the allowed amount shall be paid to the hearing aid provider by the covered individual.

Genetic Inborn Errors of Metabolism Disorders (IEM)

A genetic Inborn Error of Metabolism is a rare, inherited disorder that results in metabolism problems or enzyme deficiencies. It is present at birth and can result in death if untreated and includes but is not limited to the following diseases: Glutaric Acidemia, Isovaleric Acidemia, Maple Syrup Urine Disease, Methylmalonic Acidemia, Phenylketonuria, Propionic Acidemia, Tyrosinemia, and Urea Cycle Defects.

We shall provide coverage for treatment for Inborn Errors of Metabolism for which medically standard methods of diagnosis, treatment, and monitoring exist. Such treatments include special

diets that eliminate or replace certain nutrients, taking enzyme replacements or other supplements to support metabolism, treating the blood to remove toxic products of metabolism, clinical services, biochemical analysis, medical supplies, prescription drugs, and corrective lenses for certain conditions. Covered services under this section must be performed by providers with specific training in diagnosing, managing, monitoring, and controlling patients diagnosed with genetic Inborn Errors of Metabolism by nutritional and medical assessment.

Special Medical Foods for Genetic Inborn Errors of Metabolism
The Plan will cover special medical foods to treat inborn errors of metabolism. Special medical foods include nutritional substances that:

- Are intended for the medical and nutritional management of a patient with limited capacity to metabolize ordinary food;
- Are specifically processed or formulated to be distinct in one or more nutrients that is present in natural foods;
- Are formulated to be consumed or administered internally; and
- Are essential for optimal growth, health and metabolic homeostasis.

Coverage is subject to applicable deductibles, coinsurance, and copayments, for low protein food products for treatment of inherited metabolic diseases, if the low protein food products are medically necessary and, if applicable, are obtained from a source approved by the health insurance issuer, provided coverage will not be denied if the health insurance issuer does not approve a source.

Special medical foods must be obtained from a Plan participating vendor or provider, and must be prescribed by a physician for the treatment of an inborn error of metabolism. We cover formulas necessary to treat phenylketonuria or a heritable disease to the same extent that we provide coverage for drugs that are available only on the orders of physician.

Habilitative Services
Habilitative Services and devices help a person keep, learn or improve the skills and functions required for daily living. Such functions may include eating and bathing. The Plan covers Habilitative Services such as physical and occupational therapy, speech-language pathology, and other services for people with disabilities.

Autism Spectrum Disorder
"Autism spectrum disorder" means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified.

Coverage includes well-baby and well-child screenings, at the ages of 18 and 24 months, for diagnosing the presence of Autism Spectrum Disorder as well as treatment of Autism Spectrum Disorder through speech, occupational, and physical therapy and applied behavioral analysis. Providers of these services must be certified, registered, or licensed to provide these services. In addition, providers must be recognized and accepted by an appropriate agency of the United States or certified as a or acting as under the supervision of such a provider.

Coverage is limited to all generally recognized services in the treatment plan as prescribed by the Member's Primary Care Physician. Generally recognized services may include:

- (1) Evaluation and assessment services;
- (2) Applied behavior analysis;
- (3) Behavior training and behavior management;
- (4) Speech therapy;
- (5) Occupational therapy;
- (6) Physical therapy;
- (7) Psychological and psychiatric Care; or
- (8) Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Some services may need to be preauthorized by the Plan.

Home Health Care Services

Medically necessary home health services are covered under certain conditions. You must be confined to the home, require skilled care and be unable to receive medical care on an ambulatory outpatient basis. You do not need to be confined in a hospital or other Health Care Facility. Home health services must be provided by a licensed and qualified provider. Coverage is limited under this Plan. Please review your *Schedule of Benefits* for details.

Home health services may include:

- Visits from professional nurses including but not limited to; registered nurses, licensed professional nurses, and other participating health professionals such as physical, occupational and respiratory therapists, speech pathologists, home health aides, social workers and dieticians;
- The administration or use of consumable medical supplies and DME by professional staff during an authorized home health visit;
- Home infusion therapy; and
- Covered drugs and medications prescribed by a participating provider for the duration of home health services.

Physical, occupational, respiratory, and speech therapy provided in the home will be covered by the Plan. These are limited to services provided on the written order of a provider provided the order is renewed at least every sixty (60) days.

Inpatient Hospital Services

The Plan covers inpatient hospital services when medically necessary. Services include the treatment and evaluation of conditions for which outpatient care would not be appropriate. inpatient hospital services include:

- Semi-private room and board;
- Use of intensive care unit services;
- Pre-admission testing;

- Medications, biologicals, fluids and chemotherapy;
- Meals;
- Medically necessary special diet and nutritional supplements;
- Dressings and casts;
- Medically necessary general nursing care and special duty nursing;
- The use of the operating room and related facilities;
- Whole blood and blood, including the cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the Member;
- Administration of whole blood and blood plasma;
- X-rays, laboratory and other diagnostic services;
- Anesthesia and oxygen services;
- Inhalation therapy (respiratory therapy);
- Radiation therapy; and
- Other services provided in an acute care hospital.

Inpatient Acute Care Hospital Services require preauthorization; please refer to the preauthorization section for more information.

Inpatient Long Term Acute Care

The Plan covers Long Term Acute Care (LTAC) hospitalizations when medically necessary. LTAC hospitals provide care for Members that require longer-term inpatient care due to complex conditions that cannot be treated at a facility with a lower level of care. LTAC may include pulmonary care, advanced wound care, and critical care services.

Services that are covered by the Plan include:

- Laboratory testing;
- Respiratory therapy;
- Three (3) or more IV antibiotics, other IV medications, TPN, and IV fluids;
- Pain management;
- Limited Rehabilitation, including physical, occupational, cognitive, and speech therapy;
- Frequent vital sign, neurologic sign, or vascular checks;
- Cardiac monitoring;
- Medication monitoring;
- Nutrition management;
- Fluid management, intake and output, and daily weights; and
- Education for the patient, family, and/or the patient's caregivers.

Inpatient Long Term Acute Care hospital services require preauthorization; please refer to the preauthorization section for more information.

Inpatient Physician Care Services

The Plan covers inpatient services provided by physicians or other health professionals. These services must be medically necessary. Inpatient physician care services include services performed, prescribed, or supervised by physicians or other health professionals, including:

- Diagnostic;
- Therapeutic;
- Medical;
- Surgical;
- Preventative;
- Referral; and
- Consultative Health Care Services.

Inpatient Rehabilitation Services

The Plan covers inpatient services at an acute Rehabilitation facility. These services must be medically necessary. These services are also covered services for children with developmental delays and include occupational therapy evaluations and services; physical therapy evaluations and services; speech therapy evaluations and services; and dietary or nutritional evaluations.

Services must be rendered by a licensed and qualified provider and include the following:

- Semi-private room and board;
- Physician services;
- Skilled nursing services;
- Skilled therapy services (PT/OT/ST);
- Multidisciplinary team services (dietician, MSW services);
- Medications, biologicals, fluids;
- Meals, including medically necessary diet and nutritional supplements;
- X-rays, laboratory and other diagnostic services; and
- Oxygen and inhalation therapy (respiratory therapy).

Inpatient rehabilitation services require preauthorization, please refer to the preauthorization section for more information.

Interpreter Services for the Deaf and Hard of Hearing

Includes coverage for expenses incurred by any Member who is deaf or hard of hearing for services performed by a qualified interpreter/transliterator, other than a family member of the Member, when such services are used by the Member in connection with medical treatment or diagnostic consultations performed by a health care provider.

Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society (UHMS). Hyperbaric Oxygen Therapy is excluded for any other condition. Hyperbaric Oxygen Therapy requires

preauthorization and services must be provided by a participating provider in order to be covered.

Mental Health Services, Behavioral Health Treatment, Alcoholism and Substance Abuse Services

Alcohol and Substance Abuse Services

This Plan will cover the diagnosis and treatment of substance abuse, which includes alcohol and drug abuse disorders in an inpatient and outpatient setting.

Inpatient services include hospitalization for alcohol and substance abuse detoxification, partial hospitalization. Inpatient services require preauthorization, and all services must be furnished by a licensed and qualified provider.

Outpatient services include assessment, outpatient detoxification, individual, family or couple therapy and counseling, intensive outpatient program (IOP), group therapy, as well as medication management by a licensed and qualified Provider.

Behavioral Health Treatment

This Plan will cover the diagnosis and treatment of behavioral disorders or mental illness disorders in an inpatient and outpatient setting.

Inpatient services include hospitalization and electroconvulsive therapy (ECT). Inpatient and ECT services do require preauthorization and must be furnished by a licensed and qualified provider. Continued stay must meet medical necessity criteria and any applicable state law requirements.

Outpatient services include assessment, individual, group, family or couple therapy and counseling, intensive outpatient program (IOP), electroconvulsive therapy (ECT) and medication management. All services must be provided by a licensed and qualified provider.

Nutritional Support and Supplements

This Plan will cover the following nutritional supplements that are prescribed by a licensed and qualified Provider:

- Nutritional supplements for prenatal care for a pregnant Member;
- Nutritional supplements when medically necessary to replace a specific documented deficiency;
- Nutritional supplements when medically necessary and administered by injection at the provider’s office;
- Enteral formulas or products, as nutritional support, when administered by enteral tube feedings;
- Total Parental Nutrition (TPN) through intravenous catheters via central or peripheral veins; and
- Special ,edical foods as listed in the IEM benefit section of this Contract.

Some nutritional support and supplements require preauthorization; please refer to the preauthorization section for more information.

Nutritional Evaluation
The Plan covers dietary evaluations and counseling for the medical management of a documented disease. This includes coverage for obesity. These services must be obtained from a licensed and qualified Provider or a registered dietician. Refer to the exclusions section of this Contract for further details.

Metastatic or Unresectable Tumors
The Plan covers metastatic, unresectable tumors, or other advanced cancers with a medically necessary drug prescribed by a physician if the drug is approved by the United States Food and Drug Administration for the treatment of the specific mutation of the patient's cancer, even if the treatment is for a different type of tumor. Coverage is included for an initial treatment period of three (3) months. Coverage shall continue after the initial treatment period, if the treating physician certifies that the drug is medically necessary based on documented improvement of the patient.

Oral Anticancer Medications
The Plan covers a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells with the same coverage terms as intravenously administered or injected cancer medications that are covered services. Prior authorization is required.

Oral Surgery
The Plan covers oral surgery benefits only for the following services or procedures:

- Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.
- Extraction of impacted teeth.
- Dental care and treatment including surgery and dental appliances required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (In this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge and may have fillings or a root canal)
- Excision of exostoses or tori of the jaws and hard palate.
- Incision and drainage of abscess and treatment of cellulitis.
- Incision of accessory sinuses, salivary glands, and salivary ducts.
- Anesthesia for the above services or procedures when rendered by an oral surgeon.
- Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
- Anesthesia when rendered in a hospital setting and for associated hospital charges when a Member’s mental or physical condition requires dental treatment to be rendered in a

hospital setting. Anesthesia benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders.

- Benefits are available for dental services not otherwise covered by the Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth.

Outpatient Medical Services

The Plan covers outpatient hospital and/or ambulatory surgical procedures. These services must be medically necessary and prescribed by your Primary Care Provider or attending health care professional. Services may be provided at a hospital; a physician's office; or any other appropriately licensed facility. The provider delivering services must be licensed to practice; and must be practicing under authority of the health care plan, a medical group, an independent practice association or other authority as applicable by state law.

Outpatient Hospital or Ambulatory Surgical Procedures and Services may include:

- Primary care and specialist physician services;
- Pre-admission testing;
- Outpatient services by other providers;
- Diagnostic services, including laboratory, imaging and radiological services;
- Therapeutic radiology services;
- Prenatal services;
- Outpatient rehabilitation therapies, including physical therapy, speech therapy and occupational therapy;
- Home health services, as prescribed or directed by the responsible physician or other authority designated by the Plan;
- Preventative services required by law, including certain periodic health examinations for adults, immunizations for children, well-child care from birth, cancer screenings relating to mammography, pap test, prostate cancer or colorectal cancer, eye and ear examinations for children through age seventeen (17), and immunizations for adults;
- Treatment for PKU and other genetic disorders;
- Outpatient mental health visits;
- Emergency service
- Physician and surgeon services;
- Diagnostic laboratory tests, x-rays and pathology services;
- Pre-surgical testing;
- Whole blood, including cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the enrollee;
- Administration of blood, blood plasma and other biologicals;
- Dressings, casts and sterile tray services;
- Medical supplies;
- Private duty nursing;

- Outpatient hospital services, including treatment services, ambulatory surgery services, diagnostic services (including laboratory, radiology, and imaging services); and
- Anesthetics and/or anesthesia services.
- COVID-19 diagnostic tests, antibody tests, and antiviral drugs when ordered by a physician.

Some outpatient hospital or ambulatory services require preauthorization; please refer to the preauthorization section for more information.

Practitioner/Provider Services
Practitioner/provider services are those services that are reasonably required to maintain good health. These services include, but are not limited to, periodic examinations and office visits.

Medical Office Visits
The Plan will cover primary care and specialist services for the diagnosis and treatment of an illness or injury. Primary care and specialist office visits are not subject to the deductible other than:

- Chemotherapy performed in a physician's Office
- Other items listed in your *Summary of Benefits and Coverage*

Allergy Treatment
Coverage is provided for allergy consultation, testing, treatment and injections by an allergy specialist or immunologist.

Second Opinions
Second Opinions can be obtained from in-network participating Providers without need for preauthorization. If we determine, in consultation with a participating provider, that a second opinion is not available in network, coverage is limited to one out of network consultation per diagnosis. An out of network second opinion requires preauthorization by us.

Prescription Drugs/Medications
The Plan will provide coverage for drugs, supplies, supplements, and administration of a drug (if such services would not otherwise be excluded from coverage) when prescribed by a licensed and qualified provider and obtained at a pharmacy or through the Plan's mail order program. Coverage for prescription drugs includes generic, brand name or non-preferred drugs.

We use a Formulary, which is a list of prescription drugs and intravenous infusions that are covered by the Plan. The *Formulary* includes drugs for a variety of disease states and conditions. Periodically, the *Formulary* is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. Any drug or intravenous infusion that is on the *Formulary* when you start the plan, will be available to you until the contract that you are on ends.

Prior to a change in coverage of a particular prescription drug or intravenous infusion for which the Member has been covered for at least the preceding sixty (60) days the Plan will provide a notice of proposed change no less than sixty (60) days prior to the effective date of change. Additionally, the Member has the right to appeal the proposed change during the sixty (60) day notice period.

Sometimes it is medically necessary for a Member to use a drug and intravenous infusions that is not on the *Formulary*. When this occurs, the prescribing physician may request an exception for coverage through the Plan's Pharmacy Exception Center. In addition, some of the *Formulary* drugs and intravenous infusions may require a preauthorization, a step therapy requirement, or may have quantity limits before coverage. See the exclusions section for more information on prescription drugs that are not covered. If you have questions regarding the *Formulary* or regarding your prescription drug benefits, call Member Services for assistance or look at the *Formulary* at https://www.christushealthplan.org/member-resources/pharmacy. Additional information regarding your prescription drug cost sharing including copays, out of pocket limits, limitations and exclusions can be found in the *Schedule of Benefits*. Information about the mail order program can be found at https://www.christushealthplan.org/memberresources/pharmacy.

Any applicable sales tax imposed on prescription drugs will be included in the cost of the prescription drugs in determining the Member's coinsurance and our financial responsibility. We will cover the cost of sales tax imposed on eligible prescription drugs, unless the total prescription drug cost is less than the member's copayment in which case, the Member must pay the prescription drug cost and sales tax.

Step therapy protocol complies with all mandated requirements, which includes disclosing an exceptions request process to you and disclosing your expedited adverse determination appeal rights and external review rights for denials of exception requests. Your expedited approval or denial of a step therapy failed first protocol override requests will be responded to within seventy-two (72) hours of receipt. In cases where exigent circumstances exist, an approval or denial will be completed within twenty-four (24) hours of receipt. If the health plan fails to comply with the timelines provided, the override request shall be considered approved.

An override of the step therapy protocol will be expeditiously granted if the provider, using sound clinical evidence, can demonstrate any of the following:

- The preferred treatment required under the step therapy or fail first protocol has been ineffective in the treatment of the patient's disease or medical condition.
- The patient has tried the required prescription drug while under his current or a previous health insurance or health coverage plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the patient and known characteristics of the drug regimen.

- The preferred treatment required under the step therapy or fail first protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient.
- The patient is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on his current health coverage plan or the immediately preceding health coverage plan, the patient received coverage for the prescription drug.
- The required prescription drug is not in the best interest of the patient based on medical necessity as evidenced by valid documentation submitted by the provider.

In the case of a denial the member and the prescribing practitioner will be provided with the reason for the denial, an alternative covered medication, and information regarding the procedure for appeal of the denial if applicable.

Approval of a step therapy or fail first protocol override request shall include clear authorization of coverage for the prescription drug prescribed by the patient's provider, provided the drug is covered under the health coverage plan.

Denial of a step therapy or fail first protocol override request shall not be considered a final adverse determination and shall be eligible for an appeal of coverage determination.

Step therapy or fail first protocol shall not be longer than the customary period for the medication when the treatment is demonstrated by the prescribing practitioner to be clinically ineffective.

Step therapy or fail first protocols are not required for the treatment of stage-four advanced, metastatic cancer or associated conditions if at least one of the following criteria is met:

- The prescribed drug or drug regimen has the United States Food and Drug Administration approved indication.
- The prescribed drug or drug regimen has the National Comprehensive Cancer Network Drugs and Biologics Compendium indication.
- The prescribed drug or drug regimen is supported by peer-reviewed, evidenced-based medical literature.

Step therapy or fail first protocols are not required for a prescription or order for a ventilator when either of the following applies:

- The ventilator requires frequent or substantial servicing as classified by the Centers for Medicare and Medicaid Services
- There is clinical evidence or patient history that suggests the alternative treatments required under the protocol will be less effective or cause an adverse reaction to the patient

Some prescription drugs may be limited to a specialty pharmacy, or a specific pharmacy based upon FDA approval. Cost sharing for specialty drugs is limited to $150 per prescription for a standard thirty (30)-day supply. This limit is only applicable **after** any deductible is reached, **and** until the individual's maximum out-of-pocket limit has been reached.

If a Member received out-of-area emergency care and had a prescription filled, the Plan requires that the claim be submitted for reimbursement no later than one year (365 days) following the date of service. The claim must contain an itemized statement of expenses.

You are required to pay for your covered prescription drugs according to the lesser of:

- The copayment;
- The allowable claim amount for the prescription drug; or
- The amount you would pay for the prescription drug if you purchased the drug without using your health coverage.

If you receive a partial supply of a prescription drug from your pharmacy, the cost-sharing amount will be prorated based on the number of days' supply of the drug actually dispensed. If you are needing eye drops to treat a chronic eye disease or condition, you may have your eye drops refilled on or before the last day of the prescribed dosage period and:

- not earlier than the twenty-first (21st) day after the date a prescription for a thirty (30) day supply of eye drops is dispensed;
- not earlier than the forty-second (42nd) day after the date a prescription for a sixty (60) day supply of eye drops is dispensed; or
- not earlier than the sixty-third (63rd) day after the date a prescription for a ninety (90) day supply of eye drops is dispensed.

We have established a medication synchronization plan. This is a plan established for the purpose of synchronizing the filling or refilling of multiple prescriptions.

This Plan's cost-sharing amounts may result in an excess consumer cost burden for covered prescription drugs. Excess consumer cost burden means an amount charged to a Member for a covered prescription drug that is greater than the amount that the Plan pays, or would pay absent the Members cost sharing, after accounting for the Plans estimate of at least fifty (50%) percent of future rebate payments for the Members actual point of sale prescription drug claim.

Reconstructive Surgery

This Plan will cover medically necessary services for surgery from which an improvement in physiologic function can reasonably be expected and performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease.

Reconstructive Surgeries for Craniofacial Abnormalities

The Plan covers "reconstructive surgery for craniofacial abnormalities," which is surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Rehabilitation Therapy
Rehabilitation therapy includes physical; speech; occupational; and cardiac and pulmonary therapy. These therapies are covered by the Plan when it has been determined that they can be expected to result in significant improvement of a Member's physical condition. These services may be needed as a result of an injury; surgery or an acute medical condition. Related occupational therapy is provided for the purpose of training Members to perform the activities of daily living.

Skilled Nursing Facility Care
Inpatient services at a skilled nursing facility are covered under your Plan. These services must be medically necessary, preauthorized, and be furnished by a licensed and qualified provider. Covered services are limited as stated in the *Schedule of Benefits* and include:

- Semi-private room and board;
- Skilled and general nursing services;
- Physician visits;
- Limited Rehabilitative therapy;
- X-rays; and
- Administration of covered drugs, medications, biologicals and fluids.

Smoking Cessation Counseling/Program
Diagnostic services and smoking cessation counseling, as set forth below, and certain smoking cessation drugs as set forth on the *Formulary*.

- Diagnostic services necessary to identify tobacco use, use-related Conditions and dependence.
- Group counseling, including classes or a telephone Quit Line, are covered through a Participating Provider. No Cost Sharing applies and there are no dollar limits or visit maximums.

Please contact Member Services at 1-844-282-3025 for more information.

Group counseling, including classes or a telephone quit line, are covered through a participating provider. No cost sharing applies and there are no dollar limits or visit maximums.

Please contact Member Services at 1-844-282-3025 for more information.

Transplants
The Plan will cover human organ and tissue transplant services when preauthorized; and services are received from Plan-approved facilities within the United States.

The recipient of an organ transplant must be a Member at the time of services. The term recipient is defined to include a Member receiving authorized transplant-related services during any of the following:

- (a) Evaluation,
- (b) Candidacy,
- (c) Transplant event, or
- (d) Post-transplant care.

Coverage is subject to the conditions and limitations outlined in this Contract.

Definition of Transplant Services
Transplant services include medical, surgical and hospital services for the recipient. This Plan also covers organ procurement needed for human-to-human organ, bone, or tissue transplant.

The types of solid human organ transplants covered include, but are not limited to, kidney, kidney/pancreas, cornea, heart, heart/lung, liver, some bowel, pancreas, and 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 cases will be determined on a case-by-case basis. Contact the plan for more details regarding if your transplant is covered.

The types of tissue transplants covered include, but are not limited to, blood transfusions, autologous parathyroid transplants, bone and cartilage grafting, skin grafting, autologous islet cell transplants, and 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 transplant procedures will be determined on a case-by-case basis.

The types of bone marrow transplants covered include, but are not limited to, allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered. Also covered are 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 determined on a case- by-case basis.

Preauthorization
Transplant services must be preauthorized by the Plan. Preauthorization is based on an evaluation conducted by a Plan-approved transplant facility and on the relevant evidence-based medical guidelines.

A Member may seek authorization from the health plan for dual transplant listing. The second listing must be within a separate or different organ procurement organization. While dual listing is authorized, payment will be made to only one facility for the actual transplant event.

Organ Procurement Costs
The Plan will cover costs directly related to the procurement of an organ from a cadaver or from a live donor. Surgery needed for organ removal; organ transit and the transportation; hospitalization and surgery of a live donor are also covered by the Plan. Compatibility testing that is done prior to procurement is covered if it is determined to be medically necessary by the Plan.

Transplant Travel
Travel expenses incurred in connection with a pre-approved transplant are covered up to $10,000 per lifetime. Benefits for transportation, lodging, and food are available to Members only if they are the recipient of a pre-approved organ/tissue transplant from a Plan approved provider. Transplant travel must be preauthorized by the Plan.

Covered travel expenses for a Member receiving a transplant will include charges for:

- Transportation to and from the transplant site, including charges for a rental car used during a period of care at the transplant facility;
- Lodging while at, or traveling to and from the transplant site;
- Food while at, or traveling to and from, the transplant site.

The Plan will also cover travel expenses for one companion to accompany the patient as described above. Patients that are minors are allowed travel benefits for themselves, one or both parents, or a parent and a designated companion. A companion may be a spouse, a family member, a legal guardian, or any person not related to the Member but actively involved in the Member's care.

The following travel expenses travel expenses are excluded from coverage:

- Travel costs incurred due to travel within sixty (60) miles of the Member's home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products; and
- Charges for transportation that exceed coach rates.

Immunosuppressive Drugs for Organ Transplants

The Plan will cover inpatient immunosuppressive drugs for organ transplants. Prescription drugs may be covered. Please refer to your Schedule of Benefits for information regarding your prescription drug benefits.

Vision Care (Pediatric)
The benefits meet the FEDVIP 2014 Vision Plan requirements.

- One wellness eye exam every twelve (12) months.
- One pair of glasses (frames and lenses) or contact lenses, in lieu of glasses, every twelve (12) months.

    - Choice of glass or plastic lenses, lenticular lenses, fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses, polycarbonate lenses, scratch resistant coating, and low vision benefits.
    - Minor repairs to eyeglasses, covered in full
    - Replacement lenses and frame, covered in full
- One comprehensive low vision evaluation every five years, including low vision aids and four follow-up care visits.

Women's Health Care
Please see the SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES Section of this Contract.
The Plan covers certain services related to women's health care. Some covered services are:

- Prenatal care, including nutritional supplements that are medically necessary and prescribed by a physician;
- Maternity Support Services by a Doula
- Mammograms, or breast ultrasounds, for screening and diagnosis. These services include but are not limited to low-dose mammography screenings, including digital and mammography or breast tomosynthesis, and contrast-enhanced mammogram performed at a designated imaging facility.
    - At a minimum, the Plan shall cover one annual mammogram to persons age thirty-five (35) and older; women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual MRI starting at age twenty-five (25) and annual mammography starting at age thirty (30). Annual mammography (DBT preferred modality) and access to supplemental imaging starting at age thirty-five (35) upon recommendation by her physician if the woman has a predicted lifetime risk greater than twenty percent by any validated model published in peer reviewed medical literature.
- Diagnostic imaging, as either a diagnostic mammogram, or breast ultrasound screening, or breast resonance imaging for breast cancer designed to evaluate an abnormality.
- Breast Cancer Chemoprevention counseling for women at higher risk;
- Cytologic Screenings (Pap tests) including a screening for papillomavirus to determine the presence of precancerous or cancerous conditions and other health problems, including the CA 125 blood test. These tests are available for women age thirteen (13) or older; and for women who are at risk of cancer, or at risk of other health conditions that can be identified through a cytological screening;
- Human papillomavirus vaccine available to female Members age nine (9) to fourteen (14) years of age;
- Breast and ovarian cancer genetic testing (BRCA1 and BRCA2) and genetic counseling based on family history.
- Screening for gestational diabetes;
- Counseling and screening for HIV and other sexually transmitted diseases;
- Screening and counseling for interpersonal and domestic violence and abuse;

- Mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts; prostheses; and complications resulting from a mastectomy, including lymphedema, contralateral prophylactic mastectomies, and a partial mastectomy (a full unilateral or bilateral mastectomy as chosen by the patient and physician);
- Direct access to qualified obstetric and gynecological care for female Members.
- Coverage for diagnostic imaging is provided at the same level of coverage provided for the minimum mammography examination.

Maternity Care
Maternity Care is covered as shown on your *Schedule of Benefits*. You are entitled to receive the maternity services and benefits listed in this section. Inpatient covered services may require preauthorization by the Plan before services are provided; provided however, that no preauthorization is required for

- (1) Forty-eight (48) hours of inpatient care following a vaginal delivery or ninety-six (96) hours of inpatient care following a Cesarean section or
- (2) Post-partum care.

Prenatal Maternity Care
Coverage for Prenatal Care includes:

- A minimum of one prenatal office visit per month during the first two (2) trimesters of pregnancy;
- A minimum of two (2) office visits per month during the seventh (7^{th}) and eighth (8^{th}) months; and
- A minimum of one office visit per week during the ninth (9^{th}) month and until term by a participating provider.

Each office visit shall also include; prenatal counseling and education, necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the participating provider/practitioner. This is based upon recognized medical criteria for the risk group of which the patient is a Member.

Complications of pregnancy are covered under this Contract in the same manner as other illnesses or sicknesses. Complications of pregnancy mean conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and non-elective

cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Obstetrical Care
Maternity Care includes coverage for obstetrical care, including participating physician's services, participating Licensed Certified Nurse Midwife's services, participating delivery room, and other medically necessary services directly associated with delivery.

Services Provided by a Licensed Certified Nurse Midwife
The services of a Licensed Certified Nurse Midwife are covered, subject to the following limitations:

- The Licensed Certified Nurse Midwife is a participating provider.
- The Licensed Certified Nurse Midwife's services must be provided under the supervision of a participating licensed obstetrician or a licensed family practice provider.
- The services must be provided in preparation for, or in connection with, the delivery of a newborn infant at a site that is covered under this aternity benefit.
- For the purposes of this maternity benefit, the only allowable sites of delivery are a Participating hospital or a licensed birthing center. The combined fees of the Licensed Certified Nurse Midwife and any attending or supervising physician(s), for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the physician had he/she been the sole provider of those services.

Delivery Services
Medical, surgical, and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy are covered. Coverage for a mother shall be available for a minimum of forty-eight (48) hours of inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a Cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending physician or provider in consultation with the mother and must include appropriate post-delivery care in either the mother's home, the physician's office, a healthcare facility, or another appropriate location.

Transportation, including air transport to the nearest available appropriately licensed health care facility, is available for medically high-risk pregnant women with an impending delivery of a potentially viable infant. When necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care health care facility, is covered.

Postpartum Care
Maternity Care includes postpartum visits. Postpartum care in the home is covered in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such persons

shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

Coverage for postpartum care in the home includes a minimum of three (3) home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

If your medication for postpartum depression requires step therapy or preauthorization due to a lack of approved indication by the United States Food and Drug Administration, your provider may request an override.

Breast feeding support, supplies and counseling
The following benefits and services are covered at no cost to the Member when received from a participating provider:

- Member must have a prescription for a manual breast pump, supplies, and counseling to prove that the Member gave birth.
- Member will be provided with one (1) manual breast pump. One (1) replacement manual breast pump is allowed for each following birth. A replacement set of associated supplies is allowed per Member per year. Supplies include such items as breast pump, tubing and pads.
- If it is deemed medically necessary for the Member to use an electric breast pump, the Member's Durable Medical Equipment benefit would apply and may include a cost share.
- Breastfeeding counseling services are limited to a duration of one (1) year.

Alpha-fetoprotein IV Screening
The alpha-fetoprotein IV screening test for pregnant women screens for certain genetic abnormalities in the fetus. This test generally occurs between the sixteenth (16th) and twentieth (20th) week of pregnancy.

Newborn and Adopted Children Coverage
The Plan will cover injury or illness of a newborn child. The child can be natural or adopted or in a "placement for adoption" status. This includes circumcision for newborn males, and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Ground or air transportation to the nearest available Tertiary Care Facility is covered when necessary to protect the life of the infant.

Nutritional Supplements
This maternity benefit includes coverage for medically necessary nutritional supplements listed on the *Formulary* (as directed by the attending participating provider/practitioner). This Plan also covers inpatient and outpatient benefits for up to two (2) months for medically necessary

pasteurized donor human milk upon prescription of an infant's pediatrician or licensed pediatric provider stating that the infant is medically or physically unable to receive maternal human milk or participate in breastfeeding, or the infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities. This donor human milk may only be obtained from a member bank of the Human Milk Banking Association of North America.

Additional Women's Health Care Benefits

Mastectomy Care
The Plan shall offer forty-eight (48) hours of Inpatient care for a mastectomy; and twenty-four (24) hours of Inpatient care following lymph node dissection for the treatment of breast cancer. The Plan will also cover mastectomy-related services; including all stages of breast reconstruction and surgery to achieve symmetry between the breasts; prostheses; and any complications resulting from a mastectomy, including lymphedema and contralateral prophylactic mastectomies. Requests for reconstruction after initial reconstruction post-mastectomy require Preauthorization, and clinical information must be reviewed by a Medical Director for Medical Necessity.

Osteoporosis Coverage
Services related to the diagnosis, treatment, and appropriate management of osteoporosis when medically necessary for the following Member:

- An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment;
- An individual receiving long-term steroid shot; and
- An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

Perimenopausal and menopausal care
We will provide coverage for any medically necessary care or treatment without requiring preauthorization or step-therapy for any medication administered or prescribed for hormone replacement therapy used to treat symptoms of menopause or perimenopause.

SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES

CHRISTUS Health Plan Louisiana is an affiliate of a Catholic health care system, which is subject to the Ethical and Religious Directives for Catholic Health Care Services. Based on religious beliefs, we cannot promote or condone the performance of certain services. Such services include sterilization, tubal ligation and artificial contraceptives, or any counseling or referrals for such services, when performed for family planning purposes. However, some of these services are designated under federal law as covered essential health benefits for women with reproductive capacity; these covered services may include:

- FDA-approved contraceptive methods (not including abortifacient drugs), such as:
    - Barrier methods (used during intercourse), like diaphragms and sponges

    - Hormonal methods, like birth control pills and vaginal rings
    - Implanted devices, like intrauterine devices (IUDs)
    - Emergency contraception, like Plan B® and Ella®
    - Sterilization procedures
    - Patient education and counseling
- FDA-approved sterilization procedures
- Patient education and counseling

These services are covered without a member copayment or deductible when provided by an in-network provider, even if you have not met your deductible.

Direct abortion is not a covered benefit. The termination of a pregnancy is a covered benefit only in the following circumstances: 1) as a result of treating a proportionately serious pathological condition of a pregnant woman, and 2) when the intervention cannot be safely postponed until the fetus is viable.

If you are in need of these services, please consult with your Primary Care Provider.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your Contract with us.

Mastectomy or Lymph Node Dissection
Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by us has either a mastectomy or a lymph node dissection, we will provide coverage for inpatient care fora minimum of:

- Forty-eight (48) hours following a mastectomy, and
- Twenty-four (24) hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not:

- (a) Deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
- (b) Provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
- (c) Reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or

- (d) Provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy
Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy. All stages of the reconstruction of the breast on which mastectomy has been performed will be covered, including, but not limited to:

- Liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity;
- Tattooing the areola of the breast;
- Surgical adjustments of the non-mastectomized breast; and
- Unforeseen medical complications, which may require additional reconstruction in the future, and prostheses and physical complications, including but not limited to lymphedemas.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- All stages of the reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.
- And contralateral prophylactic mastectomies.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual
Pursuant to La. R.S. 22:1077.1, CHRISTUS shall cover annual preventive cancer screenings for a Member who was previously diagnosed with breast cancer, completed treatment for breast cancer, underwent a bilateral mastectomy, and was subsequently determined to be clear of cancer.

Additionally, your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema and contralateral prophylactic mastectomies).

Examinations for Detection of Prostate Cancer
Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- a physical examination for the detection of prostate cancer; and
- a prostate-specific antigen test for each covered male who is
    - At least fifty (50) years of age; or
    - At least forty (40) years of age with a family history of prostate cancer or other prostate cancer risk factors
- coverage for a medically necessary second visit for follow up care within sixty (60) days

Coverage and/or Benefits for Fertility Preservation for Cancer Patients
CHRISTUS shall cover fertility preservation services for a Covered Individual who has been diagnosed or undergoes a medical treatment for cancer that may directly or indirectly cause iatrogenic infertility. We will cover the cost associated with storage of oocytes and sperm for a minimum of 3 years.

Inpatient Stay following Birth of a Child
For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- Forty-eight (48) hours following an uncomplicated vaginal delivery, and
- Ninety-six (96) hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the forty-eight (48) or ninety-six (96) hours has expired, ee will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not:

- (a) Modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
- (b) Offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
- (c) Refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
- (d) Reduce payments or reimbursements below the usual and customary rate; or
- (f) Penalize a physician for recommending inpatient care for the mother and/or the newborn child.

Coverage for Tests for Detection of Colorectal Cancer
Benefits are provided, for each person enrolled in the plan who is forty-five (45) years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

- aAnnual FIT (Fecal Immunochemical Test for blood); or
- Flexible sigmoidoscopy performed every five (5) to ten (10) years, CT colonography every five (5) years or the FIT-fecal DNA test every three (3) years or capsule colonoscopy every five (5) years; or
- A colonoscopy performed every ten (10) years beginning at age forty-five (45).

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer
Coverage is provided for each woman enrolled in the plan who is eighteen (18) years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call us at 1-844¬282-3025, or write to us at:

CHRISTUS Health Plan
Attn: Member Service Department
5101 North O'Connor Boulevard
Irving, Texas 75039

EXCLUSIONS

This Contract only covered certain medically necessary healthcare benefits. This EXCLUSIONS section lists services that are specifically excluded from coverage under this Contract. All other benefits and services not specifically listed in the COVERED BENEFITS section of this Contract are also excluded services.

If you are uncertain about whether a service or item is covered by this Contract, please contact Member Services at 1-844-282-3025 before the service or item is provided.

The following are specifically excluded from coverage:

- **Abortions**
  - Direct abortions are not a covered benefit.
- **Acupuncture**
- **Autopsies and Ambulance Services**
  - Autopsy costs for deceased Members.
  - Ambulance services to the coroner's office or to a mortuary, unless the ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.
- **Bariatric Surgery**
- **Before or After Coverage Period**
  - Services received, items purchased, prescriptions filled or expenses incurred before the effective date of coverage under this Contract or after the effective date of termination of coverage.
- **Clinical Trials**
  - Any Clinical Trials that do not meet the requirements of the COVERED BENEFITS section of this Contract.
  - Costs of Clinical Trials that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.
  - Services from non-participating providers, unless services are not available from a participating provider. Preauthorization is required for any out-of-network services, which must be provided in Louisiana.
  - Costs of a non-FDA approved investigational drug, device or procedure which is not exempt from having an investigational new drug application.
  - Costs associated with managing the research associated with the Clinical Trial.
  - Costs of tests necessary for the research of the Clinical Trial.
  - Costs paid for or not charged by the Clinical Trial providers.
- **Certified Hospital Care Benefits**
  - Food, housing and delivered meals.
  - Volunteer services.
  - Personal or comfort items.
  - Homemaker or housekeeping services.
  - Private duty nursing.

- **Clothing or Protective Devices**
  - Clothing or other protective devices, including photoprotective clothing, windshield tinting, lighting fixtures or other items or devices whether prescribed or not.
- **Complementary Therapies**
  - Chiropractic Services, except as specified in COVERED BENEFITS.
  - Biofeedback, except as specified in COVERED BENEFITS.
- **Cosmetic Surgery**
  - Cosmetic therapy, drugs or medications, or procedures for the purpose of changing appearance.
  - Any surgical or non-surgical procedures that are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from injury, congenital defects or disease. Reconstructive surgery following a mastectomy is not considered cosmetic surgery and will be covered.
- **Circumcisions**
  - Performed other than for newborn stays, unless medically necessary.
- **Dental Services**
  - There is no routine dental coverage for adults. Dental services related to accidental injury are COVERED BENEFITS.
  - Dental care and dental x-rays for are allowable for children only as specified under the COVERED BENEFITS.
- **Durable Medical Equipment**
  - Upgraded or deluxe Durable Medical Equipment
  - Convenience items, including items for comfort and ease and not primarily medical in nature, such as shower seats, bath grab bars, shades for wheelchairs, pillows, fans, special beds and chairs, and other items.
  - Duplicate Durable Medical Equipment items.
  - Repair or replacement of Durable Medical Equipment due to loss, neglect, misuse, abuse to, or to improve appearance or convenience.
  - Repair or replacement of items under the manufacturer or supplier's warranty.
  - Additional wheelchairs, if the Member has a functional wheelchair.
- **Excessive Charges**
  - Charges or costs in excess of usual, customary and reasonable charges.
- **Exercise Equipment and Services**
  - Exercise equipment, videos, personal trainers, club memberships and weight reduction programs.
- **Experimental, Investigational, Medicines, Treatments, Procedures, Devices or Services – See Definitions section for further details regarding "Experimental or Investigational".**
- **Extracorporeal shock wave therapy**
  - Unless otherwise covered in the Contract.
- **Foot Care**

- Routine foot care, such as treatment of flat feet or other structural misalignments of the removal of corns, and calluses, unless medically necessary.

- **Hair Loss**
  - Hair loss or baldness treatments, medications, supplies and devices, regardless of medical cause of hair loss or baldness.
- **Home Health Care Services**
  - Custodial Care needs that can be performed by non-licensed medical personnel to meet normal activities of daily living.
  - Respite care.
- **Infertility Services**
  - Fertility preservation coverage and benefits are included for Covered Individuals who have been diagnosed with or undergoing medical treatment for cancer that may directly or indirectly cause iatrogenic infertility.
- **Long-Term Care**
  - Not covered for adults or children
- **Male Health Care**
  - Contraceptive coverage
  - Family planning services
  - Sterilization procedures
- **Mental Health and Alcoholism and Substance Abuse**
  - Bereavement and sexual counseling.
  - Psychological testing when not medically necessary.
  - Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems.
  - Treatment in a halfway house.
- **Military Service Disabilities**
  - Care for military service-connected disabilities to which you are legally entitled to and for which facilities are reasonable available to you.
- **Nutritional Supports and Supplements**
  - Baby food (including formula or breast milk), unless otherwise covered in this plan, or other regular grocery products that can be used with the enteral system for oral or tube feedings.
- **Out-of-Network Services Not Authorized**
  - Services received out of network that require preauthorization if preauthorization was not obtained.
- **Orthotic Appliances**
  - Functional foot orthotics, including those for plantar fasciitis, pes planus (flat feet), heel spurs and other conditions, orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints, except when medically necessary..
  - Custom-fitted Orthotics, except for knee-foot-ankle orthosis (KAFO) and/or ankle-foot orthosis (AFO) for Members who meet nationally recognized guidelines.

- **Prescription Drugs/Medicines**
    - Compounded prescription drugs/medicines.
    - New medications for which the determination of criteria for coverage have not yet been established by ss.
    - Over the counter (OTC) medications and drugs, except as listed on the *Formulary*.
    - Prescription drugs/medicines that require a preauthorization if no preauthorization was obtained.
    - Prescription drugs/medicines purchased outside the United States.
    - Replacement prescription drugs/medicines resulting from loss, theft, or destruction.
    - Prescription drugs/medicine, medicines, treatments, or devices that we determine are experimental or investigational.
    - Treatments and medications for the purpose of weight reduction or control, except as specified in COVERED BENEFITS.
    - Nutritional supplements as prescribed by the attending provider or as sole source of nutrition.
    - Infant formula, under any circumstance.
    - Prescription drugs/medications for the treatment of sexual dysfunction or infertility will not be covered unless caused by cancer treatment
    - Prescription drugs/medicines for cosmetic purposes.
- **Provider Services**
    - Services provided by an excluded provider.
    - Telephone visits, except as set forth in COVERED BENEFITS.
    - Electronic mail by a provider or consultation by telephone for which a charge is made to the patient.
    - Get acquainted visits without physical assessment or diagnostic or therapeutic intervention.
- **Prosthetic Devices**
    - Artificial aids including speech synthesis devices, except as specified in COVERED BENEFITS.
- **Reconstructive Surgery for Cosmetic Purposes**
    - Cosmetic Surgery (examples include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery, asymptomatic scar revision, microphlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.
- **Rehabilitation and Therapy**
    - Athletic trainers or treatments by athletic trainers.
    - Vocational rehabilitation services
        - For information regarding treatment of chronic conditions such as, but not limited to, muscular dystrophy, Down syndrome, and cerebral palsy, contact the Plan to discuss potential coverage.

- **Services Covered Under Another Program**
    - Services for which you or your Dependent are eligible under any governmental program (except Medicaid), to the extent determined by law.
    - Services for which, in the absence of any health service plan, no charge would be made to you or your Dependent.
- **Sexual Dysfunction**
    - Treatment for sexual dysfunction including but not limited to medications, counseling, clinics, and procedures is not a covered benefit unless caused by cancer treatment.
- **Skilled Nursing Facility Care**
    - Custodial or domiciliary care.
- **Speech Therapy**
    - Additional benefits beyond those listed in COVERED BENEFITS.
- **Smoking Cessation (except as specified in COVERED BENEFITS)**
    - Hypnotherapy for smoking cessation counseling
    - Over the counter drugs, unless listed on the *Formulary*.
    - Acupuncture for smoking cessation purposes.
- **Transplant Services**
    - Non-human organ transplants, except for porcine (pig) heart valve
    - Transportation costs for deceased Members
    - Medical and hospital services of an organ transplant donor when the transplant recipient is not a Member or the transplant procedure is not a covered benefit.
    - Travel and lodging, except as specified in COVERED BENEFITS.
- **Treatment While Incarcerated**
    - Services or supplies a Member receives while in custody of any state or federal law enforcement authorities, including while in jail or prison, after being adjudicated or convicted of a criminal offense.
- **Vision Care**
    - Routine vision care and eye refractions, except as specified in COVERED BENEFITS.
    - Corrective eyeglasses or sunglasses, frames, lenses, contact lenses, or fittings, except as specified in COVERED BENEFITS.
    - Eye refractive procedures, including radial keratotomy, laser procedures and other techniques.
    - Eye movement therapy.
- **Weight Loss Programs**
    - Not covered for adults or children.
- **Women's Health Care**
    - Elective abortions under any circumstances.
    - Abortifacient drugs.
    - Family planning services, excepted as specified in SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES Section of this Contract.

- **Work-Related Illnesses or Injuries**,
- Under any circumstances.

CLAIMS

Notice of Claim
Written notice of any claim must be given to us within **twenty** (**20) days** after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter or as reasonably possible. Failure to give notice within twenty (20) days will not invalidate or reduce a claim if notice is given as soon as reasonably possible.

Notice given by or on behalf of the Member to us or to any authorized agent of the Plan, with information sufficient to identify the Member, shall be deemed notice to us.

Claim Forms
You may call or write to us to notify us of a claim. Upon receipt of notice from you, we will furnish you, or the Member who is the contract holder for this Contract, the forms needed for filing a proof of loss (a "claim"). Forms will be furnished within fifteen (15) days after we receive notice from you. You may also access our website, www.christushealthplan.org, to obtain a claim form.

Claim Submission
Written claims must be furnished to us within 365 days after the date of service. However, in case of a claim for loss for which we provide any periodic payment contingent upon continuing loss, this claim may be furnished within 365 days after termination of each period for which we are liable. Failure to submit a claim within the time required will not invalidate nor reduce any benefit if it is not reasonably possible to submit a claim within 365 days, provided:

- it was not reasonably possible to provide proof in that time; and
- the proof is given within one year from the date proof of loss was otherwise required. This one-year limit will not apply in the absence of legal capacity.

We will notify you of the acceptance or rejection of a claim no later than the fifteenth (15^{th}) business day after receipt of all items.

Payment of Claims
Benefits payable under this Contract will be paid within twenty-five (25) days of notice of acceptance of your claim. Where the Contract provides for periodic payments, the benefits will accrue and be paid monthly, subject to submission of a clean claim.

A claim will be considered a "clean" claim if it contains all of the information required by us to process for payment in accordance with the benefits without additional information. For example, a claim may not be "clean" if it is incomplete, lacks medical record documentation, is suspicious or appears to be fraudulent, or suggests improper medical practice by the provider.

Claims submitted for services received by a deceased Member will be payable in accordance with the beneficiary designation and the provisions respecting such payments. If no such designation or provision is provided, claims will be payable to the estate of the Member. Any

other claims unpaid at the Member's death may, at our option, be paid to the beneficiary. All other claims will be payable to the Member or to the provider, at our option.

The CHRISTUS Health Plan shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Out-of-Network Emergency Claims and Payment
If you receive emergency care services from non-participating providers, you are responsible for submitting the claim. The claim must contain an itemized statement of treatment, expenses, and diagnosis. The itemized claim or statement must be submitted to us as soon as possible at the following address:

CHRISTUS Health Plan
Attn: Claims Department
5101 North O'Connor Boulevard
Irving, Texas 75039

Fraud and Abuse
Anyone who knowingly submits a false or fraudulent claim for payment of a loss, or engages in deception or misrepresentation to obtain an unauthorized benefit, may be guilty of a crime and subject to civil fines and criminal penalties.

We may terminate coverage for any type of fraudulent activity by you or the Members covered by this Contract.

Subrogation
This section will apply when another party is, or may be considered liable for a Member's injury, illness or other condition. This includes insurance carriers who are financially liable; settlements or awards relating to the Member's injury, sickness, or other condition; medical malpractice lawsuits; and other sources of liability other than this Contract.

We are subrogated to all of the rights of the Member against any party liable for the Member's injury or illness; or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits that may have been paid by us. We may assert this right without consent from the Member.

This right includes, but is not limited to, the Member's rights under uninsured and underinsured motorist coverage; any no-fault insurance; medical payment coverage (auto, homeowners or otherwise); Workers' Compensation coverage; or other insurance, as well as the Member's rights under the Plan to bring an action to clarify his or her rights under that insurance.

Any right of recovery from third parties on the part of the Plan, whether by subrogation or reimbursement, is secondary to the Member's right to be fully compensated for their damages. The Plan will share in any legal expenses incurred.

We are not obligated in any way to pursue this right independently or on behalf of the Member, but may choose to pursue our rights to reimbursement at our sole discretion.

The Member is obligated to cooperate with us and its agents in order to protect our subrogation rights. Cooperation with us means you will:

- provide us with any relevant information requested;
- sign and deliver such documents as reasonably requested by us to secure the subrogation claim;
- obtain our consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice our subrogation rights. If a Member fails to obtain prior written consent from us and agrees to a settlement or releases any party from liability for payment of medical expenses, or otherwise fails to cooperate with this provision, including executing any documents required herein, the Member will be required to repay CHP for the value of any benefits that were paid under us.

If you are in an accident and another person or entity may be legally liable to you, notify the Plan's Subrogation Services immediately at:

CHRISTUS Health Plan
Attn: COB, Subrogation and Recovery Department
PO Box 169001
Irving, Texas 75016-9001

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this Contractprovides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Indemnities payable under this Contract for any loss other than loss for which this Contractprovides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its Contract terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense as provided for in §303A.(a. -e.) of Regulation 32.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage except those enumerated in LSA-R.S. 22:1000 A.3C; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one Plan. When this plan is primary, it determines payment for its benefits first before those of any

other Plan without considering any other Plan's benefits. When this plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care service or expense, including deductibles, coinsurance and copayments, that is covered in full or at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any Plan covering the person is not an allowable expense.

The following are examples of expenses that are and are not an allowable expense:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all Plans.
- The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:
(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, Contract holder, subscriber or retiree is the primary plan and the Plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, Contract holder, subscriber or retiree is the Secondary plan and the other Plan is the primary plan.
(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

- If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the custodial parent;
    - The Plan covering the spouse of the custodial parent;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child covered under spouse's plan. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits,

this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, Contract holder, subscriber or retiree longer is the primary plan and the Plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible, coinsurance, copayments and any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that Plan and other closed panel plans.

Effect on the Benefits of This Plan

(1) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

- Determine its obligation to pay or provide benefits under its contract;
- Determine whether a benefit reserve has been recorded for the covered person; and
- Determine whether there are any unpaid allowable expenses during that claims determination period.

(2) If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

(3) If a covered person is enrolled in two or more closed panel plans, and if for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. CHRISTUS Health Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CONSUMER EXPLANATORY BOOKLET COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

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

The COB provision applies when a Member has health care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its Contract terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense as provided for in §303A.(a.-e.) of Regulation 32.

Please see the Coordination of Benefits Notice located at Appendix C- Explanation for Secondary Plans on the Purpose and Use of the Benefit Reserve on the LDI website under the following link: www.ldi.la.gov/consumers/resources-publications/consumer-publications. You may also request that a Coordination of Benefits Notice be mailed to you by contacting Member Services at (844) 282-3025.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called “coordination of benefits” to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

COB is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact the Louisiana Department of Insurance.

Primary or Secondary?

The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the Member has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When This Plan is secondary, it determines its

benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense.

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

When This Plan is Primary
If you or a family member is covered under another plan in addition to this one, we will be primary when:
Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- the claim is for the health care expenses of your child who is covered by this plan and:
    - you are married and your birthday is earlier in the year than your spouse's, or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or
    - you are separated or divorced and you have informed us of a court order that makes you responsible for the child's health care expenses; or
    - there is no court order, but you have custody of the child.

Other Situations
We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary
When we are the primary plan, we will pay the benefits in accord with the terms of your contract, just as if you had no other health care coverage under any other plan.

When This Plan is Secondary
We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary
When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense, including copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

If there is a difference between the amount the plans allow, we will usually base our payment on the higher amount. However, if one plan has a contract with the health care provider or physician and the other does not, our combined payments will not be more than the contracted amount. Health maintenance organizations and preferred provider organizations usually have contracts with their providers.

We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid equal 100 percent of the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.

We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain prior authorization as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

APPEALS AND COMPLAINT PROCESS

You have a right to appeal any determination we make that denies payment on your claim or your request for coverage of a health care service, treatment requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.. You have the right to:

- Appeal an adverse determination to us;
- To external review; and/or
- To file a complaint.

We have a department that takes care of appeals and complaints. If you disagree with our decisions, you may ask for a review by filing an appeal or compliant. We will never retaliate against a Member in any way for filing an appeal or complaint.

For all verbal appeals, including expedited appeals, call 1-844-282-0380.

For all written appeals, including expedited appeals, fax 866-416-2840 or mail to:

CHRISTUS Health Plan
Appeals Processing
PO Box 169009
Irving, TX 75016

Confidentiality
CHRISTUS Health Plan, the Commissioner, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of members when reviewing complaints shall treat and maintain such records and information as confidential except as otherwise provided by federal and Louisiana law.

CHRISTUS Health Plan has procedures to ensure the confidential treatment and maintenance of identifiable medical records and information submitted as part of any complaint.

Who Can Help You
Member Services can help you. If you have a concern about a person, a service, the quality of your care, or your benefits, you can contact the Member Services toll-free at 1-844-282-3025.

Member Services will make every effort to resolve your complaint or concern the first time it is brought to our attention. If the Member Services representative is not able to resolve your complaint or concern, you can file a complaint or appeal.

The Office of Consumer Advocacy & Diversity of the Louisiana Department of Insurance is also available to assist in completing an appeal and throughout all levels of the appeal process at 1-225-342-5900.

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 our initial adverse benefit determination for aAdministrative appeals and internal medical appeals. Requests submitted to us after one hundred eighty (180) days of our initial adverse benefit determination will not be considered.

A covered person or his authorized representative may not file a subsequent request for a standard or expedited external review involving the same adverse determination or final adverse determination for which the covered person has already received a standard or expedited external review decision.

If you have questions or needs assistance, you may call our Member Service department.
A Member has the right to appoint an authorized representative to speak on their behalf in their appeals. An authorized representative is a person to whom the Member has given written consent to represent him in an internal or external review of an adverse benefit determination. The authorized representative may be the Member's treating provider, if the Member appoints the provider in writing.

We will determine if a Member's appeal is an administrative appeal or a medical appeal.

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.

   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.

   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 of coverage.

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 Members two (2) standard levels of medical appeals, including an internal review of the initial adverse benefit determination, then an external review.

a. Internal Medical Appeals

A physician or other healthcare professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial adverse benefit determination, will review the internal medical necessity appeal.

If the internal medical appeal is overturned, we will reprocess the Member's claim, if any. If the internal medical appeal is upheld, we will inform the Member of their right to begin the external appeal process if the adverse benefit determination meets the criteria.

The internal medical appeal decision will be mailed to the Member, his authorized representative, or a provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreeing that an extension of time is warranted.

b. External Medical Appeal and Rescission of Coverage

For medical appeals and rescission of coverage, 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.

If you disagree with the internal medical appeal decision or rescission of coverage, a written request for an external appeal must be submitted within four months of receipt of the internal medical appeal decision or rescission of coverage.

Requests submitted to us after four (4) months of receipt of the internal medical appeal decision or rescission of coverage will not be considered. You are required to sign the form included in the internal medical appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by your provider will not be accepted without this form completed with your signature. The Member can submit additional information to the IRO.

Within five (5) business days after the date of receipt of the notice provided, we will provide the IRO all pertinent information necessary to conduct the appeal. The external review will be completed within forty-one (41) 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 contract. This appeals process shall constitute your sole recourse in disputes concerning determinations of whether a health service or item is or was medically necessary or investigational, except to the extent that other remedies are available under State or Federal law.

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

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 the Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard medical appeal decision.

An expedited appeal also includes requests concerning an admission, availability of care, continued stay, or healthcare service for a Member currently 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 the covered person's treating physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the adverse benefit determination would be significantly less effective if not promptly initiated.

Expedited appeals are not provided for review of services previously rendered.

An expedited appeal shall be made available to, and may be initiated by the Member, his authorized representative, or a provider authorized to act on the Member's behalf. Requests for an expedited appeal may be verbal or written.

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 the Member or the provider acting on behalf of the Member, the appeal may be elevated to an expedited external appeal.

   If an expedited internal medical appeal does not meet the expedited appeal criteria or does not include the physician attestation signature, the appeal will follow the standard appeal process and timeframe.

2. Expedited External Medical Appeal

   An expedited external 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 as soon as possible from the time of receipt.

If denied, the member may appeal to the Louisiana Commissioner of Insurance. If you would like to make your request in writing, send it to:

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

If you can access the internet, you can file your complaint online at:
www.ldi.la.gov

Informal Reconsideration

Your appeal rights are outlined above. 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.

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.

Retrospective Utilization Review
If a retrospective utilization review is conducted and results in an adverse determination, the we will notify you and your Provider of the adverse determination within a reasonable period, but not later than thirty (30) days after the date when the claim was received.

The thirty (30) day period may be extended for another fifteen (15) days if we determine that an extension is necessary due to matters beyond our control and you and your provider are notified of the extension with expected determination date within thirty (30) days of when the claim was received.

If an extension is needed because you or your provider have to submit information necessary to reach a decision on the request, the notice will specifically describe the required information necessary to make the determination and will give you and your provider at least forty-five (45) days from the date of the receipt of the notice of extension to provide the specified information.

Complaint Process
If you notify us with an oral or written complaint, we will send you, not later than the fifth (5^{th}) business day after the date of receiving the complaint, a letter acknowledging the date we received the complaint. If your complaint was received orally, we will enclose a one-page complaint form with the complaint acknowledgement letter. You do not have to return the complaint form, but we ask that you send it back because the form will help us resolve the complaint. Our letter will include our complaint procedures and time frames for resolution. We will resolve your complaint not later than the thirtieth (30th) calendar day after the date. If your complaint concerns an emergency or a denial of continued hospitalization, we shall investigate and resolve your complaint in accordance with the immediacy of your condition, but in no event later than one business day after we receive your complaint.

After we have reviewed your compliant, we will issue you a response letter that:

- Explains the resolution of the complaint,
- States the specific medical or contractual reasons for the resolution,
- States the specialization of any physician or provider consulted, and
- Contains a complete description of the process for appealing the decision, along with the deadlines for the appeals process and the deadlines for the final decision on the appeal.

Filing Complaints with the Louisiana Department of Insurance
Any person, including persons who have attempted to resolve a complaint through our appeals and complaint process and who are dissatisfied with the resolution, may complain to the

Louisiana Department of Insurance by calling toll-free to 1-800-259-5300. If you would like to make your request in writing, send it to:

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

If you can access the internet, you can file your complaint online at:
www.ldi.la.gov

Exhaustion of Remedies

You must complete levels of our appeal and complaint process applicable to you and any regulatory/statutory review process available to you under state or federal law before you file a legal action. Completion of these administrative and regulatory processes assures that both you and we have a full and fair opportunity to resolve any disputes regarding the terms and conditions contained in this contract.

Culturally and Linguistically Appropriate Manner of Notice

When we send you information, we will make sure we:

- Provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claim and appeals (including external review) in any applicable non-English language;
- Provide, upon request, a notice in any applicable non-English language;
- include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care plan; and
-
- Send notices in any non-English language that is spoken by more that have more than ten percent (10%) non-English speaking of our service population, we will send the notice in the non-English language. We use the standard issued by the department of health and human services (HHS). The standard is found at http://cciio.cms.gov/resources/factsheets/clas-data.html.

PAYMENT OF PREMIUM

Payment of Premium
You are responsible for paying your premium on time. The first premium is due with the enrollment application. Other premiums are due on the first day of month for the coverage provided during that month, Premium period means monthly. All premiums are payable to us.

You must pay the required premium to us as it becomes due. If we do not receive your premium on time, or within the grace period we will terminate coverage in accordance with the TERMINATION OF COVERAGE section of this Contract. We will not be financially responsible for any services rendered after that date.

Grace Period
Members Without Advanced Payments of the Federal Premium Tax Credit

A grace period of thirty (30) days will be granted for the payment of each premium due after the first premium. During the grace period, coverage shall continue in force. If payment is not received within the thirty (30) day grace period, coverage will be terminated as of the last day of the month before the grace period began. We will mail you a notice of non-payment fifteen (15) days prior to the end of your grace period.

Example: April payment is due April 1. If payment is not received by April 30, coverage is terminated retroactive to the last day of March.

Members with Advanced Payments of the Federal Premium Tax Credit

A grace period of three months will be granted for qualified individuals who have paid at least one month's worth of premiums and are receiving advance payments of the federal premium tax credit. If we do not receive the full premium due within the three (3) -month grace period, we will terminate your coverage, on the last day of the first month during the grace period, even if advance premium tax credits are received.

We will continue to pay all appropriate claims for covered services provided to you during the first month of the grace period and will deny pharmacy claims for covered services provided to you in the second and third months of the grace period.

We will notify you and the Exchange of the nonpayment of premiums. We also will notify providers of the possibility of denied claims when You are in the second and third month of the grace period.

We will continue to collect advance premium tax credits paid on your behalf from the Department of the Treasury and will return the advance premium tax credits paid on your behalf for the second and third month of the grace period if you exhaust your grace period as described above.

Changes in Premium Payments
We reserve the right to annually change the premium payment amount for the covered benefits. We will provide at least sixty (60) days' advance notice in writing of any change to the premium payment.

Your rate may change. A few examples of why are:

- A change of residence;
- The addition of a Dependent due to a qualifying event; or
- Termination of a Dependent on a family Contract.

Recovery of Excess Benefit Overpayments
We have the right to recover any overpayments that we have made. Recovery may be from one or more of the following: any person to, for, or with respect to whom such services were provided or such payments were made; any third-party payor; any health care plan or other organization.

The right of recovery belongs to us alone. It is used at our sole discretion. If we tell you (or your legal representative if you are a minor or legally incompetent) that we are pursuing the recovery of these benefits, we ask that you cooperate with us to secure these recovery rights.

GENERAL PROVISIONS

Amendments
We will give you sixty (60) days' notice prior to any administrative change. You will receive an amendment to your Contract showing any change. This does not include changes to your benefits, as they do not change during the year.

Assignment
Except in circumstances in which payment is related to claims for emergency services provided by noncontracted health care providers, we reserve the right to pay you directly and to refuse to honor an assignment of benefits in any circumstances.

Availability of Provider Services
We do not guarantee that a particular hospital, Health Care Facility, physician, or other provider will be available in the provider network.

Circumstances Beyond Our Control
If a disaster occurs, we will make a good faith effort to help you get covered services, and we will remain responsible for payment for covered services; however, we will not be liable for damages resulting from delays, or failures due to a lack of facilities or personnel that are beyond our control. Examples of disasters are earthquakes, epidemics, war, and riots.

Clerical Error

A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Conformity with State Statutes
Any provision which, on its effective date, is in conflict with the statutes of the state in which you reside, is hereby amended to conform to the minimum requirements of such statutes and shall not be rendered invalid but shall be construed and applied as if it were in full compliance with all applicable laws.

Disclaimer of Liability
We have no control over the diagnosis, treatment, care, or other service provided to a you by any facility or provider, whether a participating or non-participating provider. We are not liable for loss or injury caused by any health care provider by reason of negligence or otherwise.

Entire Contract
This Contract and *Evidence of Coverage*, together with the *Summary of Benefits and Coverage, Schedule of Benefits,* and *Formulary*; the application; and any supplements; amendments; and endorsements collectively constitute the entire Contract between us and you. No change in this Contract is valid unless it is in writing and is approved by one of our executive officers. You will be notified of any such changes. No agent may change this Evidence of Coverage or waive any of its provisions.

Execution of a Contract – Application for Coverage
The parties acknowledge and agree that your signature or execution of the application shall be deemed to be your acceptance of the contract, including this Contract. All statements, in the absence of fraud or the intentional misrepresentation of a material fact, made by any applicant (you and/or your Dependents) shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application that is signed by the subscriber and that has been furnished to the subscriber or their representative.

Federal and State Health Care Reform
This Contract shall comply with all applicable state and federal laws, rules and regulations. Upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects our obligations under this Contract, this Contract will be modified and submitted for appropriate state and/or federal approval. We will notify you when this happens.

Fraud
We are required to cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both provider and Member activity.

Governing Law
The Contract is issued in the State of Louisiana and shall be interpreted under the laws of the State of Louisiana and applicable federal rules and regulation.

Hospitalization on the Effective Date of Coverage
If you are confined in a hospital on the effective date of your coverage, you must notify the Plan of the hospitalization within two (2) days; or as soon as reasonably possible thereafter.

Identification Cards
We issue Identification (ID) Cards to you for identification purposes only. Possession of our ID Card confers no rights to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the ID Card must, in fact, be a Member on whose behalf all applicable Contract charges have actually been paid. If you or any family member permits the use of your ID Card by any other person, all your rights and those of other members of your family pursuant to this Contract may be immediately terminated at our discretion. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Contract shall be charged therefore at the rates generally charged in the area for medical, hospital and other health care services.

Independent Contractors
Participating providers are not employees, representatives or agents of the Plan. They are independent contractors. The Plan is not liable or responsible for their actions or failure to act. You are encouraged to contact Member Services at 1-844-282-3025 if you are not satisfied with your care.

Legal Actions
No legal action shall be brought to recover on this Plan by the group or Member prior to the expiration of sixty (60) days after written proof of loss has been furnished, in accordance with the requirements of state law. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Member Activity
Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate enrollment for any Member for any type of fraudulent activity. Some examples of fraudulent activity are:

- Falsifying enrollment information;
- Allowing someone else to use your ID Card;
- Forging or selling prescriptions; or
- Misrepresenting a medical condition in order to receive covered benefits to which you would not normally be entitled.

Misrepresentation of Information
If, in the first two (2) years from the effective date of your and/or your Dependents coverage, you intentionally omitted information of material fact from your application and/or you provided fraudulent information, the coverage for you and/or your Dependent shall be null and void from

the effective date. In the case of fraud, no time limits shall apply, and you will be required to pay for all benefits that we have provided. We will furnish you a signed copy of the enrollment application.

If the age of the Member has been misstated all amounts payable under this Contract shall be adjusted to reflect the premium that would have been paid for the correct age.

Misstatements
All statements made on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew a Member's coverage or reduce benefits unless:

- it is in a written enrollment application signed by the subscriber; and
- a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.
- This Contract may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application.

Notice
If we are required or permitted by this Contract to give any notice to you, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to you at the address of record on file at our principal office. You are solely responsible for ensuring the accuracy of your address of record on file with us.

Policies and Procedures
We may adopt reasonable policies, procedures, rules, and interpretations for the purposes of promoting the orderly and efficient administration of the Contract.

Practitioner/Provider Activity
If you suspect that a practitioner, pharmacy, hospital, facility or other health care professional has done any of the items listed below, please call the practitioner or provider and ask for an explanation, as there may be an error.

- Charged for services that you did not receive
- Billed more than one time for the same service
- Billed for one type of service, but gave you another service (such as charging for one type of equipment but delivering another less expensive type)
- Misrepresented information to you (such as changing your diagnosis or changing the dates that you were seen in the office)

If you are unable to resolve the issue with the provider, or if you suspect any other suspicious activity, please contact our Member Services.

Reinstatements
We may reinstate this Contract after termination without the execution of a new application or the issuance of a new identification card. Reinstatement of a policy following default in payment of premium shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten days after the date of such acceptance.

Time Limit on Certain Defenses
You must fully and accurately complete the enrollment application on behalf of yourself and any eligible dependents that you wish to enroll in the Plan. All statements, in the absence of fraud, made by the applicant on the enrollment application shall be deemed representations and not warranties. No such statements shall be used to void coverage or to reduce benefits unless contained in a written application of this Contract. In the event that a misstatement in an application is made that was NOT fraudulent or willful, we rate and collect from you the premium that would have been charged at the time coverage was effect had such misstatement not been made.

Waiver by Agents
No agent or other person, except an officer of CHRISTUS Health Plan, has the authority to waive any conditions or restrictions of this Contract, to extend the time for making payment, or to bind CHRISTUS Health Plan, by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an Endorsement or amendment in writing to this Contract or a Letter of Agreement signed by a CHRISTUS Health Plan officer.

DEFINITIONS

Unless specifically defined elsewhere, wherever used in this Contract, the following terms have the meanings given below:

Accidental Injury means a bodily injury caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection, hernia or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an accidental injury.

Acquired Brain Injury means an injury to the brain that occurs after birth, is non-congenital and non-degenerative and prevents the normal function of the brain. Brain injuries may be mild, moderate or severe and may result in memory loss, change in personality, behavior dysfunction, difficulty managing anger, impaired judgment, or loss of judgment.

Acupuncture means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

Administrative Complaint means an oral or written complaint submitted by or on behalf of a Complainant regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

- administrative practices of the health care plan that affects the availability, delivery, or quality of health care services;
- claims payment, handling or reimbursement for health care services; and
- termination of coverage.

Advance Payments of the Federal Premium Tax Credit (APFPTC) means payment of the tax credits as specified in section 36B of the US Code (as added by section 1401 of PPACA) and which are provided on an advance basis to an eligible individual enrolled in an individual QHP through an Exchange in accordance with sections 1402 and 1412 of PPACA.

Adverse Determination means:

- A determination by the Plan or its utilization review that, based on the information provided a request for a benefit under the Plan's health benefit plan upon application of any utilization review technique does not meet the Plan's requirements for medically necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided, in whole or in part, for the benefit;

- The denial, reduction, termination, or failure to provide or make payment, in whole or part, for a benefit based on a determination by a HHI (or a URO) of a covered person's eligibility to participate in the health insurance issuer's health benefit plan;
- Any perspective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or part, for a benefit under a health benefit plan; or
- A rescission of coverage determination.
- Prescription drug adverse determinations are the refusal of benefits if:
- The drug is not included in a drug formulary used by the health benefit plan and
- The enrollee's physician or other authorized prescriber has determined the drug is medically necessary.

Alcoholism means alcohol dependence or alcohol abuse meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

Allowable Charge is the amount that we have determined to be the maximum amount payable for a covered service. For covered services provided by non-participating providers, the amount payable will be either a rate agreed upon by us and the non-participating provider, or based upon our out-of-network fee schedule. The out-of-network fee schedule is the usual and customary rate based on CHRISTUS's median amount negotiated for in network services, and consistent with nationally recognized and generally accepted bundling edits and logic. Our out-of-network fee schedule is based on generally accepted industry standards and practices for determining the customary billed charge for a service, and fairly and accurately reflects market rates, including geographic differences in costs, and is consistent with nationally recognized and generally accepted bundling edits and logic.

Ambulance is a vehicle which is licensed solely as an ambulance by the local regulatory body to provide emergency transportation to a hospital or transportation from one hospital to another health care facility for those individuals who are unable to travel to receive medical care by any other means or the hospital cannot provide the needed care. Air ambulance charges are payable only for transportation from the site of an emergency to the nearest hospital that is equipped to treat the condition instead of local ambulance service.

Ambulatory Services are health care services delivered at a provider's office, clinic, medical center, or ambulatory surgical facility in which the patient's stay is no longer than twenty-four (24) hours.

Ambulatory Surgical Facility means a facility (other than a hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide ambulatory services.

Annual Out-of-pocket Maximum means a specified dollar amount of covered services received in a calendar year that is the most the Member will pay (cost sharing responsibility) for that calendar year.

Appeal means the formal process by which you, an individual acting on your behalf, or your provider of record may request reconsideration of an adverse determination.

Application means the forms that each subscriber is required to complete when enrolling for our coverage.

Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--not otherwise specified.

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Basic Health Care Services means emergency care, inpatient hospital and physician care, outpatient medical and chiropractic services, and laboratory and x-ray services. The term shall include optional coverage for mental health services for alcohol or drug abuse. With respect to chiropractic services, such services shall be provided on a referral basis at the request of the enrollee who presents a condition of an orthopedic or neurological nature necessitating referral, the treatment for which falls within the scope of a licensed chiropractor.

Behavioral Disorder is a disability characterized by displayed behaviors of sufficient duration, frequency, and intensity over a long period of time which significantly deviates from socially acceptable norms for a person’s age and situation.

Beneficiary means a person designated by a participant, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition.

Biologicals are medical compounds that are prepared from living organisms and/or their products.

Calendar Year is the period of time beginning January 1 and ending December 31 of any given year. The initial calendar year period is from a Member’s effective date of coverage and ends on December 31, which may be less than twelve (12) months.

Certification means a decision by a health plan that a health care service requested by a provider or grievant has been reviewed and, based upon the information available, meets the health care

plan's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Certified Nurse Midwife is any person who is licensed by the board of nursing as a Registered Nurse and who is licensed by the Louisiana Department of Health as a Certified Nurse Midwife.

Certified Nurse Practitioner is a Registered Nurse endorsed by the Board of Nursing for the expanded practice as a Certified Nurse Practitioner. A Certified Nurse Practitioner's name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the Louisiana Board of Nursing.

Clinical Trial means any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent person.

Coinsurance is the shared financial responsibility for covered expenses between the covered person and this Plan, expressed as a percentage.

Commissioner means the Louisiana Commissioner of Insurance.

Complainant means an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint.

Complaint means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation.

Concurrent Utilization Review means a form of utilization review for ongoing health care services or for an extension of treatment beyond the previously approved health care services.

Condition is a group of related diagnoses dealing with the same organ, system, or disease process.

Continuing Care Patient is an individual who, with respect to a provider or facility— is undergoing a course of treatment for a Serious and Complex condition from the provider or facility; is undergoing a course of institutional or inpatient care from the provider or facility; is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

Copayment is the amount that Members are required to pay to a participating provider or other authorized provider in connection with the provision of health care services.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Cost Sharing means any contribution Members make towards the cost of their covered health care services as defined in their Contract. This includes deductibles and copayments.

Coverage/Covered means benefits extended under this Contract, subject to the terms, conditions, limitations, and exclusions of this Contract.

Covered Benefit or Covered Service(s) means a benefit or service incurred by or on behalf of a Member for those services or supplies which are:

- Administered or ordered by a physician or other qualified provider;
- Medically necessary to the diagnosis and treatment of an injury or illness;
- Not excluded by any provision of the Contract; and
- Incurred while the Member's coverage is in force under the Contract.

A covered service is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained.

Craniomandibular means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

Creditable Coverage means coverage of an individual under (a) A group health plan; (b) Health insurance coverage; (c) Medicare coverage; (d) Medicaid; (e) Medical insurance coverage under the General Military Law; (f) A medical care program of the Indian Health Service or of a tribal organization; (g) A state health benefits risk pool; (h) A health plan offered for federal employees; (i) A public health plan; or (j) A health benefit plan provided to members of the Peace Corps. Such term does not include coverage consisting solely of coverage of excepted benefits.

Custodial Care means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a Member's condition. Custodial care also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine drugs, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Custom-fitted Orthotics means an orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in

the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to substantially prefabricated item.

Deductible is part of the contribution that Members make toward the cost of their health care, also known as cost sharing. It means the amount the Member is required to pay each calendar year, directly to the practitioner/provider in connection with covered health care services before CHRISTUS Health Plan begins to pay covered benefits. The deductible may not apply to all health care services.

Department means the Louisiana Department of insurance.

Diagnostic Service means procedures ordered by a practitioner/provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Doula is any person who has received an approved registration status from the Louisiana Doula Registry Board.

Durable Medical Equipment means equipment or supplies prescribed by a practitioner/provider that is medically necessary for the treatment of an illness or accidental injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or accidental injury, and includes items such as oxygen equipment, wheelchairs, hospital beds, crutches, and other medical equipment.

Effective Date is 12:01 a.m. of the date on which the Member's coverage begins.

Emergency Care or Emergency Care Services are health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize emergency medical conditions.

Emergency Medical Condition is a severe injury or a medical condition of a recent onset and severity, including severe pain. The injury or medical condition must be one that would lead a prudent layperson with an average knowledge of medicine and health to believe that failure to get immediate medical care could: (a) place such person's life or health in serious jeopardy; (b) result in serious impairment to bodily functions; (c) result in serious impairment to a bodily organ or part; or (d) result in serious disfigurement; (e) or for a pregnant woman, result in serious jeopardy to the health of a fetus.

Essential Health Benefits are determined by HHS under PPACA and are subject to change, but currently include the following general categories of service: ambulatory services; emergency care services; hospitalizations; maternity and newborn services; services for behavioral disorders, mental illness disorders or substance abuse conditions; prescription drugs; rehabilitative and habilitative services and devices; lab services; preventive and wellness

services; services related to chronic disease management; and pediatric services, including oral and vision care.

Exchange means the Health Insurance Exchange

Excluded Services means health care services that are not covered services and that we will not pay for.

Experimental or Investigational means a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.

Federal Cost-Sharing Reductions means reductions in cost sharing provided under federal law for an eligible individual, such as for an individual enrolled in a Silver level plan in the Exchange or for an individual who is an American Indian/Native Alaskan enrolled in a QHP in the Exchange.

Follow-up Care is the contact with, or re-examination of a patient at prescribed intervals following diagnosis or during a course of treatment.

Formulary is a listing of covered drug products selected by us in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. you may obtain your *Formulary* by calling the telephone number on your ID card.

Genetic Inborn Errors of Metabolism (IEM) means a disease caused by an inherited abnormality of body chemistry and includes the following diseases:

- Glutaric Acidemia
- Isovaleric Acidemia
- Maple Syrup Urine Disease
- Methylmalonic Acidemia
- Phenylketonuria
- Propionic Acidemia
- Tyrosinemia
- Urea Cycle Defects

Grace Period is a short period after your monthly health insurance payment is due. If you haven't made your payment, you may do so during the grace period and avoid losing your health coverage.

Habilitative Services and Devices means health care services or device that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child

who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Benefits Plan means a Health Plan or a Contract, certificate or agreement offered or issued by a health care plan or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services.

Health Care Facility means any facility providing health care services, including a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.

Health Care Plan means a person that has a valid certificate of authority in good standing to act as a health maintenance organization, nonprofit health care plan or prepaid dental plan.

Health Care Professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

Health Care Services means any services rendered by providers which include but are not limited to medical and surgical care; psychological, optometric, optic, chiropractic, podiatric, nursing, and pharmaceutical services; health education, rehabilitative, and home health services; physical therapy; inpatient and outpatient hospital services; dietary and nutritional services; laboratory and ambulance services; and any other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability. Health care services shall also mean dental care, limited to oral and maxillofacial surgery as performed by board qualified oral and maxillofacial surgeons. The term shall also include an annual Pap test for cervical cancer and minimum mammography examination as defined in La. R.S. 22:1028. No deductible permitted for annual pap test for cervical cancer and minimum mammography in or out of network pursuant to La. R.S. 22:1028(E).

Health Maintenance Organization means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

HHS means the United States Department of Health and Human Services.

Home Health Agency means an agency or organization that:

- Specializes in giving nursing care or therapeutic services in the home;
- Is licensed to provide such care or services by the appropriate licensing agency where services are performed or is certified as a Home Health Agency under Title XVlll of the Social Security Act of 1965, as amended;
- Is operating within the scope of its license of certification; and
- Maintains a complete medical record for each patient.

Home Health Agency does not mean any other similar service or agency which does not meet this definition, even if the service or agency meets some of the above requirements or provides some or all of the services which may be provided by a home health agency.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home infusion therapy includes:

- Drugs and IV solutions;
- Pharmacy compounding and dispensing services;
- All equipment and ancillary supplies necessitated by the defined therapy;
- Delivery services;
- Patient and family education; and
- Nursing services.

Hospice Care Program means an organization duly licensed to provide hospice care program services. An approved hospice must be licensed when required, Medicare-certified as a hospice, or accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) as a hospice.

Hospice Care Program Services means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice care program services is available in the home, in a skilled nursing facility, or in a special hospice care unit.

Hospital is an institution licensed, accredited or certified by the State providing health care services under the care of a physician which:

- Provides 24-hour nursing service by licensed Registered Nurses (R.N.);
- Mainly provides diagnostic and therapeutic care under the supervision of physicians while hospital confined; and
- Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more physicians.

Hospital also includes certain tax-supported institutions, which may not be required to maintain surgical facilities. Hospital does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

Illness means a sickness or disease, including all related conditions and occurrences, requiring health care services.

Independent Review Organization (IRO) means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

Injury is bodily injury due to an accident which results solely, directly and independently of disease, bodily infirmity, or any other causes.

In-network means care received from a participating provider.

Inpatient means you are a registered bed patient and are treated as such in a hospital.
Licensed Practical Nurse (LPN) means an individual who has received specialized nursing training and practical nursing experience and is duly licensed to perform nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such service.

Life-threatening Illness means a severe, serious, or acute condition for which death is probable.

Managed Care means a system or technique(s) generally used by third party payers or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;
- Contracts with selected health care providers;
- Financial incentives or disincentives for enrollees to use specific providers, services, or service sites;
- Controlled access to and coordination of services by a case manager; and
- Payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

Maternity means coverage for prenatal, intrapartum, perinatal, or postpartum care.

Maternity support services means the physical, emotional, and educational support services provided by a doula to pregnant and birthing women before, during, and after childbirth. "Maternity support services" includes postpartum bereavement support.

Medicaid means Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

Medical Director is a physician who serves to manage the provision of health care services to our Members.

Medically Necessary means a treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an illness or injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided.

A treatment, drug, device, procedure, supply or service shall not be considered as medically necessary if it:

- Is experimental, investigational or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, physician, hospital, or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the patient's condition or the quality of medical care;
- Involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- Involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual.

We may require you or your Provider to furnish peer-reviewed, evidence-based scientific literature that demonstrates that the service is required for the health of the Member.

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

Member is an individual:

- who meets each of the enrollment and eligibility requirements described in this Contract;
- who has been properly enrolled in coverage with us; and
- for whom we have received any required premium for the enrolled coverage.

Mental Illness/Disorder is any condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, or current edition), and/or Mental Disorders Section of the International Classification of Disease.

Newly Born means infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a hospital or neonatal special care unit to his home, whichever period is longer.

Non-Participating Provider means a provider that is not a participating provider and that offers out-of-area services. This may also be called an out-of-network provider.

Nutritional Support means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is covered only when enteral tube feedings are required.

Obstetrician/Gynecologist (OB/GYN) is a physician that is board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Osteopathic Obstetricians and Gynecologists.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function and improve a Member's functional ability to perform activities of daily living.

Orthotic Appliances/Devices/Orthosis means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports or eliminates motion of a weak or diseased body part.

Out-of-Network Services means health care services Obtained from a non-participating provider.

Outpatient Hospital is a place to receive covered services while not an inpatient. Services considered outpatient include, but are not limited to, services in an emergency room regardless of whether you are subsequently admitted as an inpatient in a hospital.

Participating Provider is a physician, provider, hospital or health care facility that has an agreement with us to accept our rates and payments as payment in full when providing health care services to Members. This may also be called a network provider.

Physical Therapy is therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by illness or injury that utilizes therapeutic exercise, physical modalities (as massage and electrotherapy), assistive devices, and patient education and training.

Physician is one of the following:

- A doctor of medicine, surgery, or osteopathy;
- A doctor of podiatry or a doctor of chiropractic; or
- Any other licensed provider who is required to be recognized as a physician by state law and acts within the scope of his/her license to treat an illness or injury.

Physician Assistant is a person who has graduated from a nationally recognized physician assistant or assistant surgeon program; or who is currently certified by the national commission of Physician Assistants. A Physician Assistant must be licensed to practice medicine under the supervision of a licensed physician in the state in which they practice.

Placement or "being placed", for adoption, in connection with any placement for adoption of a child with any person means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

Plan means the health benefit plan established by CHRISTUS Health Plan and selected by the Member to provide health care services to Members, as it exists on the Effective Date of this Contract or as subsequently amended as provided herein.

PPACA means the federal Patient Protection and Affordable Care Act.

Preauthorization means a decision by a health care plan that a health care service requested by a practitioner/provider or covered person has been reviewed and, based upon the information available, meets the health care plan's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Prescription Drugs are drugs for which sale or legal dispensing requires the order of a provider with legal authority to prescribe drugs.

Primary Care Physician or Primary Care Provider or PCP is the physician or other provider you see first for most health problems. Your PCP makes sure you get the care you need to keep you healthy. Your PCP also may talk with other physicians and providers about your care and refer you to them. PCPs include, but are not limited to family practice physicians; general practitioners; internists; pediatricians; Obstetricians and/or Gynecologists (OB/GYNs). Your PCP is responsible for providing your primary care services. These include annual examinations; routine immunizations; and treatment of non-emergency acute illnesses and injuries.

Primary Care Services are services provided by a PCP or primary provider of health care services.

Prosthetic Services means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost to amputation or congenital deformities to restore function, cosmesis, or both.

Provider means a duly licensed hospital, physician, or other practitioner of the healing arts that is authorized to render health care services within the scope of their license.

Provider Network means a list of the providers that are participating providers.

Qualified Health Plan or QHP means health care coverage that has been determined to meet the requirements in state and federal law for coverage to be offered through the Exchange.

Qualified Individual means, with respect to the Exchange, an individual who has been determined eligible to enroll through the Exchange in a qualified health plan in the individual or small group Exchange market.

Qualified Medical Child Support Order is an order from a State or Federal government agency or court. It requires a person to provide health care coverage for specific dependents.

Rescission of Coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Registered Nurse is an individual who has received specialized nursing training, is authorized to use the designation of (R.N.) and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitation means care for restoration (including by education or training) of a Member's prior ability to function at a level of maximum therapeutic benefit. This type of care must be acute rehabilitation, sub-acute rehabilitation, or intensive day rehabilitation, and it includes rehabilitation therapy and pain management programs. An inpatient hospitalization will be deemed to be for rehabilitation at the time the Member has been medically stabilized and begins to receive rehabilitation therapy or treatment under a pain management program.

Rehabilitation Therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available twenty-four (24) hours a day.

Respiratory Therapy means a medically supervised, individualized, physical conditioning program designed and adapted to promote and improve the lung and breathing health and wellbeing of a Member and would include simple breathing exercises and advice on posture and the use of supplementary devices that aid in removing mucus from the airways and improve the strength of the lungs. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Screening Mammography, or "low-dose mammography", means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one radiation mid-breast, with two views for each breast.

Second Opinions provide an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the medical necessity and appropriateness of the initial proposed health service.

Serious and Complex Condition is defined as, in the case of 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 in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

Service Area is the geographical area that CHRISTUS Health Plan is authorized by law to serve. CHRISTUS Health Plan's service area map is provided in this booklet.

Skilled Nursing Care refers to services ordered by a physician which require the clinical skills and professional personnel of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Skilled care is provided directly by or under the supervision of such personnel to a patient who needs those services twenty-four (24) hours a day, along with other treatment, for recovery from illness or injury. Skilled care does not include custodial care.

Skilled Nursing Facility means a place that:

- Is legally operated as a skilled nursing facility;
- Primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a physician;
- Provides continuous twenty-four (24) hours a day nursing service by or under the supervision of a Licensed Practical Nurse;
- Maintains a daily medical record on each patient; and
- Provides rehabilitation services, such as physical, occupational and speech therapy, and may provide other multidisciplinary services, such as respiratory therapy, dietician/nutrition services, and medical social work.
- Skilled nursing facility does not include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disorder, tuberculosis, or for intermediate, custodial or educational care.

Specialist is a physician who provides covered services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart conditions; and orthopedists who care for patients with certain bone, joint, or muscle conditions and psychiatrists care for Members with behavioral disorders or mental illness/disorders.

Speech Therapy is the treatment and exercises for treating voice and speech and swallowing disorders due to diagnosed illness or injury provided by a qualified provider.

Subluxation means misalignment, demonstrable by x-rays or chiropractic examination, which produces pain and is correctible by manual manipulation.

Subscriber means an individual who is the contract holder and is responsible for payment of premiums to CHRISTUS Health Plan.

Substance Abuse means alcohol, drug, or chemical abuse, overuse, or dependency.

Telehealth means a service, other than a telemedicine medical service, delivered by a health professional, licensed, certified, or otherwise entitled to practice in Louisiana and acting within the scope of the health professional's license, certification, or entitlement to a patient at a

different physical location than the health professional using telecommunications or information technology.

Temporarily Medically Disabled Mother means a woman who has recently given birth and whose physician has advised that normal travel would be hazardous to her health.

Termination Date is 11:59 pm on the last day of the month for which premiums were paid and the date that the Member's coverage ends.

Termination of Coverage means the cancellation or non-renewal of coverage provided by a health care plan to a grievant but does not include a voluntary termination by a grievant or termination of a health benefits plan.

Tertiary Care Facility is a hospital unit that provides specialized care for high-risk patients. The facility provides and coordinates transport, communication, education and data analysis systems for the geographic area that it serves.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the health care plan consistent with the federal, national, and professional practice guidelines that are used by a health care plan in determining whether to certify or deny a requested health care service.

Urgent Care means medically necessary health care services provided in emergencies or after a Primary Care Provider's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Urgent Illness is a non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are sprains; a rising fever despite having taken medication; new ear pain; an asthma attack where medications are not helping; an animal bite; an object in the eye or eye infection; a cut that may need stitches; a child with severe vomiting or diarrhea; a possible broken bone; shortness of breath; a sore throat; flu symptoms; a urinary tract infection; or a migraine headache where medicines are not relieving the pain.

Utilization Review or Utilization Management is the process of reviewing and managing a Member's medical conditions so that the Member receives the right care, by the right provider, at the right time. This process maximizes benefits and ensures quality health care.

Workers' Compensation refers to the workers' compensation plan of any of the 50 United States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands; as well as the systems provided under the Federal Employees' Compensation Act and the Longshoreman's and Harbor Workers' Compensation Act; and any other federal, state, county,

or municipal workers' compensation; occupational disease or other employer liability laws; or other legislation of similar purpose or intent.

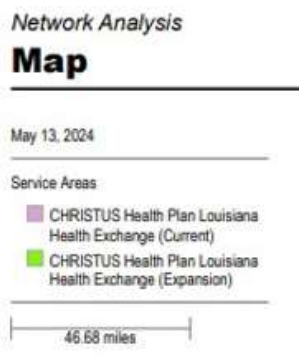
We, Our, Us, and **CHRISTUS** refers to CHRISTUS Health Plan.

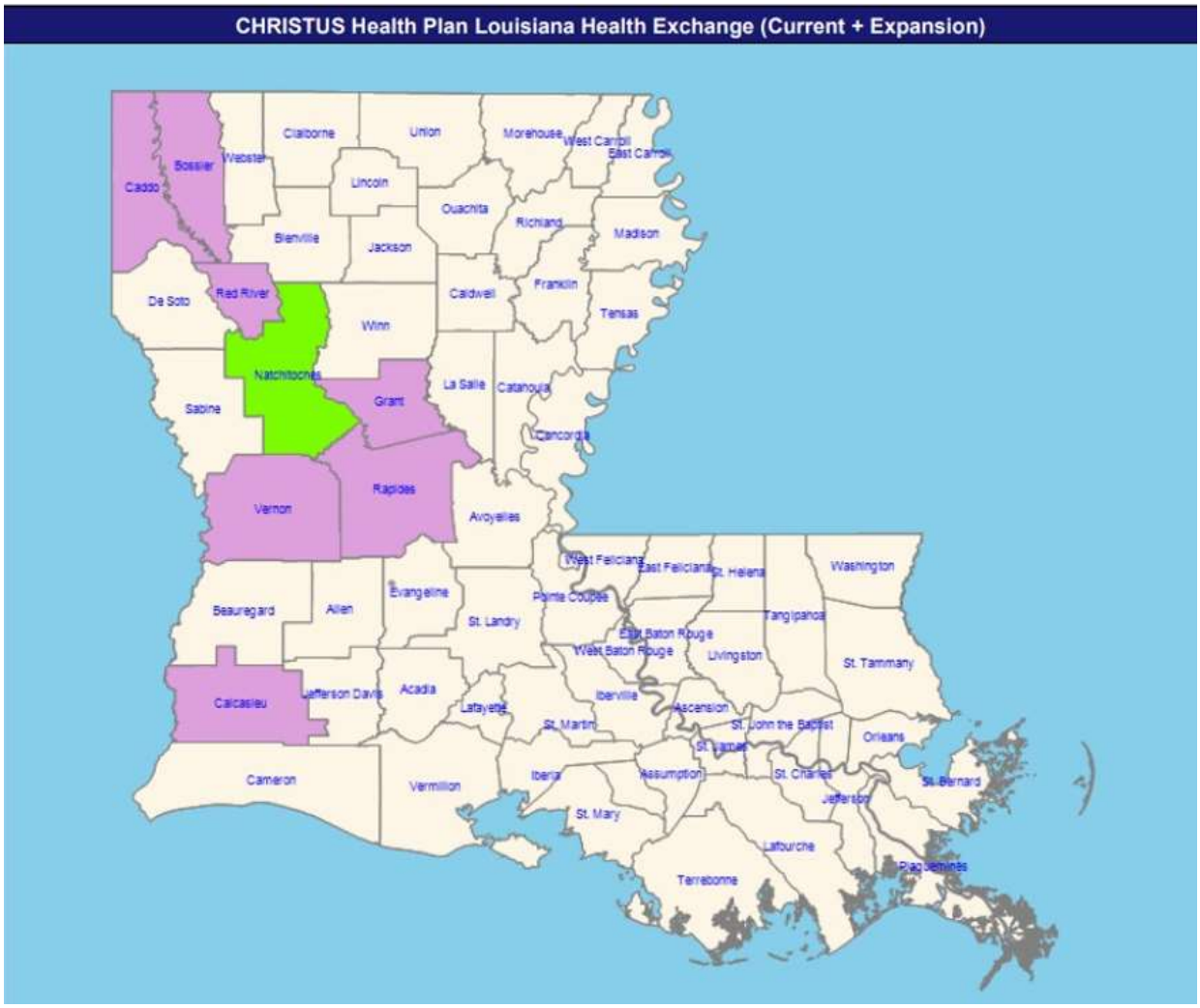
You, Your, and **Yours** refers to the Member.

Executed in the name of and on behalf of CHRISTUS Health Plan:

[Authorized CHRISTUS Health Plan Signature]

SERVICE AREA MAP




CHRISTUS Health Plan Louisiana Health Exchange (Current + Expansion)
Claiborne
Union
Morehouse
West Carroll
East Carroll
Bossier
Webster
Caddo
Lincoln
Ouachita
Richland
Madison
Bienville
Jackson
Franklin
De Soto
Red River
Caldwell
Tensas
Winn
Natchitoches
La Salle
Catahoula
Sabine
Grant
Concordia
Rapides
Vernon
Avoyelles
West Feliciana
East Feliciana
St. Helena
Washington
Evangeline
Pointe Coupee
Beauregard
Allen
St. Landry
Tangipahoa
East Baton Rouge
West Baton Rouge
Livingston
St. Tammany
Calcasieu
Jefferson Davis
Acadia
Iberville
Lafayette
Ascension
St. Martin
St. John the Baptist
Orleans
St. James
Cameron
Vermilion
Iberia
Assumption
St. Charles
St. Bernard
Jefferson
St. Mary
Lafourche
Plaquemines
Terrebonne

CHRISTUS® Health Plan

844.282.3025 | TTY 711

Monday - Friday, 8 a.m. - 5 p.m., local time

CHRISTUShealthplan.org