



Women's Contraceptive Services

Accompanies Non-Grandfathered Group Health Plans with a religious exemption to providing contraceptive services.

What kinds of women's contraceptive services are covered for you at no out-of-pocket cost?

As part of the Patient Protection and Affordable Care Act, health insurers must cover all Food and Drug Administration (FDA) approved contraceptive methods for Members of non-grandfathered group health insurance plans. Non-grandfathered plans are plans that began after the Patient Protection and Affordable Care Act was passed in March 2010.

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DISCLAIMER: The Preventive & Wellness benefits in effect are those required by state or federal law for your policy, at the time the services are rendered. To the extent this Preventive Care Services document conflicts with state or federal requirements, state and federal requirements control.



IMPORTANT NOTICE REGARDING THE AVAILABILITY OF REIMBURSEMENT FOR FEDERALLY-MANDATED CONTRACEPTIVE SERVICES

You are currently enrolled in a group health plan insured or administered by Blue Cross and Blue Shield of Louisiana (BCBSLA) or HMO Louisiana, Inc. Your employer has certified that the group health plan qualifies for an accommodation with respect to the federal requirement to cover Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that the employer will not contract, arrange, pay, or refer for contraceptive coverage. Instead, BCBSLA will provide or arrange separate payments for contraceptive services that you use as prescribed by your physician, without cost sharing when services are rendered by a Network Provider. A Network Provider is a provider that has signed an agreement with BCBSLA or another Blue Cross and Blue Shield Plan to participate as a member of the Preferred Care Provider Network or another PPO network. To obtain a list of Providers please visit www.bcbsla.com. If you have any questions about this notice, contact BCBSLA at the number on the back of your ID card.

You will no longer be eligible for reimbursement of contraceptive services if you cease to be enrolled in your group health plan. If you receive services from a provider outside of the network as described in your employer group health plan, your services will not be eligible for reimbursement without cost sharing.



CONTRACEPTIVE SERVICES REIMBURSEMENT SUMMARY

Blue Cross and Blue Shield of Louisiana will **only** reimburse for federally-mandated women's contraceptive services as described below. Federally-mandated women's contraceptive services are reimbursed at 100% if services are rendered by a Network Provider. Services will be subject to a deductible and coinsurance if they are received from a Non-Network Provider.

Covered Federally-Mandated Women's Contraceptive Services include:

- Contraceptive devices such as implantable rods and intrauterine devices (insertion and removal)
- Contraceptive drugs
- Education and counseling related to contraceptives and sterilization
- Services to place/remove/inject covered FDA-approved contraceptive methods
- Sterilization procedures such as tubal ligations

The following conditions **must be met** for these services to be reimbursed at no cost:

- Services are designated as women's contraceptive services under federal law.
- Services must be prescribed and provided by a Network Provider.

NOTE: BCBSLA is permitted to limit contraceptive services through the use of medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified under Federal law.

Definitions

Allowable Charge	The lesser of the billed charge or the amount established by the Company or negotiated as the maximum amount allowed for all Provider services covered under the terms of this reimbursement summary.
Benefits	Coverage for health care services, treatment, procedures, equipment, drugs, devices, items or supplies provided under this reimbursement summary. Benefits provided by the Company are based on the Allowable Charge for Covered Services.
Coinsurance	The sharing of Allowable Charges for Covered Services. The sharing is expressed as a pair of percentages, a Company percentage that We pay, and a Member percentage that You pay. Once the Member has



met any applicable Deductible amount, the Member's percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. The Company's percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Company	Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company).
Covered Service	A service or supply specified in this reimbursement summary for which Benefits are available when rendered by a Provider.
Deductible	The dollar amount, as shown in the Schedule of Benefits, of charges for Covered Services that a Member must pay before benefits are paid.
Network Provider	A Provider that has signed an agreement with Us or another Blue Cross and Blue Shield Plan to participate as a member of the Preferred Care Provider Network or another PPO Network. This Provider may also be referred to as a Preferred Provider or In-Network Provider.
Non-Network Provider	A Provider who is not a member of Our Preferred Care Provider Network or another Blue Cross and Blue Shield Plan PPO Network. Participating Providers and Non-Participating Providers are Non-Network Providers.
Member	A Subscriber or an enrolled Dependent.
Pharmacy Benefit Manager (PBM)	A third party administrator of prescription drug programs.
Preferred Care Network	A Provider who has entered into a contract with Us or another BlueCross and Blue Shield plan to participate in a PPO Network. We call these Providers "PPO Providers," "Preferred Providers", or "Network Providers."
Prescription Drugs	Medications for which the sale or dispensing of legally requires the order of a Physician or other health care professional and that carry the federally required product legend stipulation that such drugs may not be dispensed without a prescription, which are currently approved by the FDA for safety and effectiveness as contraceptive drugs.



Eligibility

Eligibility for reimbursement of contraceptive services is effective on the date of the first plan year that your employer group health plan attests and self-certifies that it has a religious exception to providing contraceptive coverage. You are eligible for reimbursement of contraceptive services at no cost if you are a female between the ages of 15 and 46 and enrolled in your employer's group health plan, and are not covered under another group health plan that covers contraceptive services.

When you are no longer covered under the employer group health plan or you turn 47, you will no longer be eligible for reimbursement of contraceptive services. If you have elected COBRA or state Continuation coverage through your employer group health plan, you will continue to be eligible for reimbursement so long as you are covered on the employer group plan.

Carry Your Identification Card

Your ID card identifies you as eligible for reimbursement of contraceptive services at no cost when services are rendered by a Network Provider. Please note that this ID is different than the group health plan's ID card. In order to receive reimbursement for contraceptive services, you need to make sure you present your contraceptive services ID card when you receive such services. For ID card requests, please visit our website at www.bcbsla.com or call Customer Service at the number listed on the back of your ID card. If your card is lost or stolen, please notify us immediately.

Important Information About Your Appeal Rights

You or someone you name to act for you as your authorized representative have a right to appeal any decision not to reimburse an item or service. Appeal forms and third party authorization forms are available at www.bcbsla.com.

To be eligible for an appeal, your written request must be received by us within 180 days of the date you receive a Personal Health Statement.

Please refer to the Complaint, Grievance and Appeal Procedures section of your group health plan for details on submitting appeals.

If you have questions or need assistance writing the Appeal, you may call our customer service department at 1-800-599-2583 or 1-225-291-5370.



How to File Insurance Claims for Benefits

Most Providers have entered into agreements that eliminate the need for a Member to personally file a claim for Benefits. Preferred or Participating Providers will file claims for Members either by mail or electronically. In certain situations, the Provider may request that the Member file the claim. If the Member's Provider requests they file directly with us, the following information will help the Member accurately complete the claim form. If you need to file a paper claim, send it to the address below.

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

The Member's Blue Cross and Blue Shield ID card shows the way the name of the Subscriber (appears on our records. (If the Member has Dependent coverage the name(s) are recorded as shown in the enrollment information we received.) This number is the identification to the Member's membership records and should be provided to us each time a claim is filed.

To assist in promptly handling the Member's claims, please be sure that:

- A. an appropriate claim form is used
- B. the ID number shown on the form is identical to the number on the ID card
- C. the patient's date of birth is listed
- D. the patient's relationship to the Subscriber is correctly stated
- E. all charges are itemized, whether on the claim form or on the attached statement
- F. the date of service (date of admission to a Hospital or other Provider) or date of treatment is correct
- G. the Provider includes a diagnosis code and a procedure code for each service/ treatment rendered [make sure your diagnosis code pointers are consistent with your claim form]
- H. the claim is completed and signed by the Member and the Provider

IMPORTANT NOTE: Be sure to check all claims for accuracy. The Member's ID # must be correct. It is important that the Member keep a copy of all bills and claims submitted.



Prescription Drug Claims

Most Members with Prescription Drug coverage will not be required to file claims to obtain Prescription Drug Benefits as this is done automatically for the Member who presents her ID card when obtaining prescriptions. However, if the Member must file a claim to access her Prescription Drug Benefit, the Member must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to us, may require the signature of the dispensing pharmacist. The claim form should then be sent to our Pharmacy Benefit Manager, whose telephone number may be found on the Member's ID card.

Benefits will be paid based on the Allowable Charge for the Prescription Drug.

BCBSLA will not be liable for reimbursement of contraceptive services unless proper notice is furnished to BCBSLA that Covered Services have been provided to a Member. If the Member files the claim, written notice must be given to BCBSLA within 15 months after the Member incurs the Covered Services, except in the absence of legal capacity of the Member. The notice must be on an approved claim form and include the data necessary for BCBSLA to determine benefits.

Provider Network

Members choose which Providers will render their care. If services are provided by a Network Provider, you will not have any costs. If services are received from a Non-Network Provider, your costs may be significant.

Our Preferred Care PPO (or PCare) Network consists of a select group of physicians, hospitals and other allied health professionals who have contracted with us to participate in the Blue Cross and Blue Shield of Louisiana PPO Provider Network and render services to our members. We call these Providers "PPO Providers," "Preferred Providers," or "Network Providers."

To obtain the highest level of Benefits available, the Member should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Care Provider before the service is rendered. Members may review a current paper Provider directory, check on-line at www.bcbsla.com, or contact Our Customer Service Department at the number listed on their identification (ID) card.

Health care services may be provided to you at a Network health care facility by facility-based physicians who are not contracted with us. 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 coinsurance, deductibles, and non-covered services.

Specific information about in-network and out-of-network facility-based physicians can be found at www.bcbsla.com or by calling the customer service telephone number on the back of your identification (ID) card.

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

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

A provider may be contracted with us when providing services at one location, but may be considered a Non-Network Provider when rendering services from another location. The Member should make sure to check her Provider directory to verify that the services are in-network from the location where she is seeking care.

Additionally, Providers in your network may be contracted to perform certain Covered Services, but may not be contracted in your network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with us to perform, those services will be processed at the non-network Benefit level. The Member should make sure to check her Provider directory to verify that the services are in-network when performed by the Provider or at the Provider's location.

Receiving Care Outside of the Preferred Care Network

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

We pay a lower level of Benefits when a Member uses a Provider outside the Preferred Care Network. Care obtained outside our network means the Member has out-of-pocket costs and pays a Copayment, Deductible, and/or Coinsurance which is not applicable to services provided in-network. THESE ADDITIONAL COSTS MAY BE SIGNIFICANT. In addition, we only pay a portion of those charges and it is your responsibility to pay the remainder.

We recommend that you ask Non-Network Providers to explain their billed charges to you, BEFORE you receive care outside the Network.



Services for Women *(You will pay \$0 for these services when received from a preferred care Network Provider - Prescription required)*

Your plan includes these contraceptive services...	Criteria
<ul style="list-style-type: none"> • Education and Counseling related to contraceptives and sterilization • Barrier contraceptive method – Diaphragm, Sponge, Cervical Cap, Cervical Shield, Female Condom • Emergency contraceptive method • Hormonal contraceptive method • Implantable contraceptive method – IUD, Implantable Rods • Sterilization method – Tubal Ligation, Essure 	<ul style="list-style-type: none"> • If you have reproductive capacity • Ages 15-46

Contraceptive Services Required by the Patient Protection and Affordable Care Act

We are required to cover federally recommended contraceptive services. This list of covered services changes from time to time. Check the current list at: <http://www.healthcare.gov/prevention/index.html>.





**BlueCross BlueShield
of Louisiana**

5525 Reitz Avenue

Baton Rouge, Louisiana 70809

For more information call 1-800-495-2583

www.bcbsla.com