SECTION 1: NETWORK OVERVIEW

of the Professional Provider Office Manual

TABLE OF CONTENTS

This section provides information about provider networks. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 1: NETWORK OVERVIEW

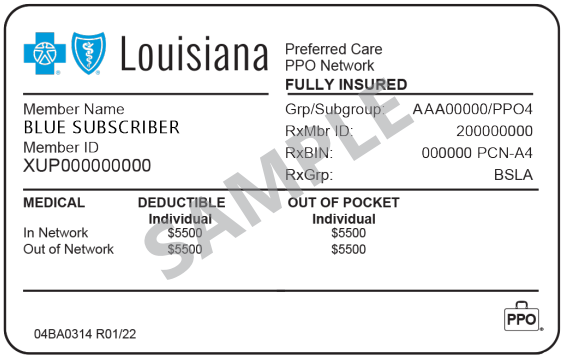
Blue Cross has worked to develop business relationships with doctors, hospitals and other healthcare providers throughout Louisiana. These relationships have allowed us to develop some of the largest, most comprehensive provider networks in the state.

With the number of insurance companies and network programs available, it can be quite challenging for providers to navigate the various administrative requirements of these programs. To help you better understand the Blue Cross networks in which you may participate, we are providing an overview of our provider network programs. You will also see examples of member ID cards associated with the various networks.

For more information on reviewing member eligibility, benefits and limitations, please use iLinkBlue (www.bcbsla.com/ilinkblue).

PREFERRED CARE PPO

Our Preferred Care PPO network includes hospitals, physicians and allied providers. Members with PPO benefit plans receive the highest level of benefits when they receive services from PPO providers.



Preferred Care PPO members are identifiable by the Blue Cross and Blue Shield of Louisiana logo and the Preferred Care PPO Network name printed on their member ID cards. The "PPO" in a suitcase logo identifies the nationwide BlueCard® Program. For more information, view the Preferred Care PPO Provider Speed Guide, available on our Provider page.

Preferred Care PPO member ID cards are issued to each member on the policy. Member ID cards are used for both medical and dental coverage when a dental network is indicated. The Preferred Care PPO network is offered statewide.

HMO LOUISIANA, INC.

HMO Louisiana is a wholly owned subsidiary of Blue Cross and Blue Shield of Louisiana. Since 1996, HMO Louisiana has worked to develop business relationships with doctors, hospitals and other healthcare providers throughout Louisiana. The HMO Louisiana provider network is a select group of physicians, hospitals and allied health providers who provide services to individuals and employer groups seeking managed care benefit plans. Our HMO Louisiana network is offered statewide.

Please Note: HMO Louisiana providers should follow the guidelines set forth in this manual. Differences and additional guidelines are indicated.

HMO Louisiana Offers Two Managed Care Benefit Plans

HMO Louisiana allows members to choose an HMO-HMO or Point of Service (POS) benefit plan. Members pay a lower copayment when they receive services from primary care providers (PCPs) and receive the highest level of benefits when they receive care from in-network providers. Fully insured HMO Louisiana members must select a primary care provider.

Health Maintenance Organization (HMO-HMO)

This benefit design is similar to the POS benefit design in that members with either an HMO-HMO or HMO-POS benefit plan access the same network of providers and have the same type of benefits, except there is no out-of-network option with the HMO-HMO benefit.

- Uses HMO Louisiana providers.
- Member is responsible for any applicable coinsurance, deductible and/or copayment.
- Member receives high-level benefits for in-network providers with authorization (if necessary).
- Member has no benefits for out-of-network providers (without Plan approval).

HMO Louisiana members enrolled in an HMO product have no benefits for services provided by non-participating providers without obtaining prior approval. When we both issue an authorization that the services are medically necessary, and approve a member to receive the medically necessary covered services from a non-participating provider, benefits will be at the highest level possible to limit the member's out-of-pocket expenses.

HMO and HMO-POS members do not have to obtain prior authorization to receive emergency medical services. A member should seek emergency care at the nearest facility.

Point of Service (HMO-POS)

Allows members to choose each time they need care—at the point of service—whether to use a network provider or go out-of-network and receive reduced benefits. Members with a HMO-POS benefit plan receive the highest level of benefits when using network providers with the proper authorization (when services require plan approval) and a lower level of benefits when receiving care that is not authorized or from providers who are not in the HMO Louisiana network.

- Uses HMO Louisiana providers
- Member is responsible for any applicable coinsurance, deductible and/or copayment
- Member receives high-level benefits for in-network providers with authorization (if necessary)

Members usually pay significant costs when using non-participating providers. This is because the amounts that providers charge for covered services are usually higher than the fees that are accepted by participating and HMO Louisiana providers. In addition, participating and HMO Louisiana providers waive the difference between the actual billed charge for covered services and the allowable charge, while non-participating providers do not. The member will pay the amounts shown in the "out-of-network" column on their schedule of benefits, and the provider may balance bill the member for all amounts not paid by Blue Cross.

There is a $1,000 penalty toward the allowable charge to HMO Louisiana POS inpatient network facilities for failure to obtain an authorization for inpatient facility confinements. No 30% penalty or $1,000 penalty will be applied to the professional services for the inpatient stay. There is no penalty for professional services rendered during the inpatient stay. For new group HMO Louisiana POS plans with deductibles, there is no copayment. Therefore, the $1,000 penalty will be applied to the Blue Cross payment based on the deductible/coinsurance benefit.

Please Note: The member's benefit plan is an agreement between the member and Blue Cross or HMO Louisiana only. Providers cannot waive the member's cost sharing obligations, such as deductibles, coinsurance (including out-of-network differentials), penalties or the balance of the bill. A claim that is filed that includes any amounts the provider waives may be a fraudulent claim because it includes amounts that the member is not being charged, and will be reduced by the total amount waived.

Non-participating Hospital Penalty

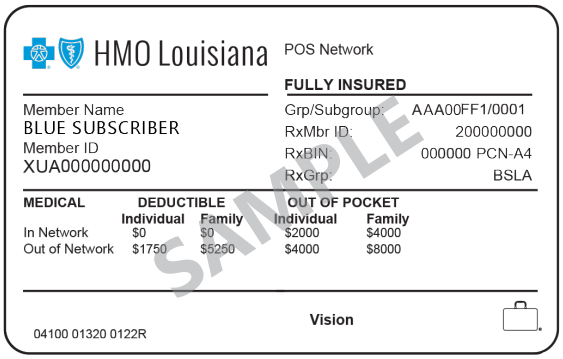
When a HMO-POS member receives covered services from a non-participating hospital, the benefits that are paid under the member's benefit plan will be reduced by 30%. This penalty is the member's responsibility. The member may also be responsible for higher copayments, coinsurances and deductibles when receiving services from non-participating providers.

HMO Louisiana Service Area

The HMO Louisiana Network is offered statewide. We rely on the vast amount of healthcare data at our disposal to identify providers who are delivering the highest-quality, most cost-efficient care among their peers. These are the providers we contract with for our HMO Louisiana network.

Identifying HMO Louisiana Members

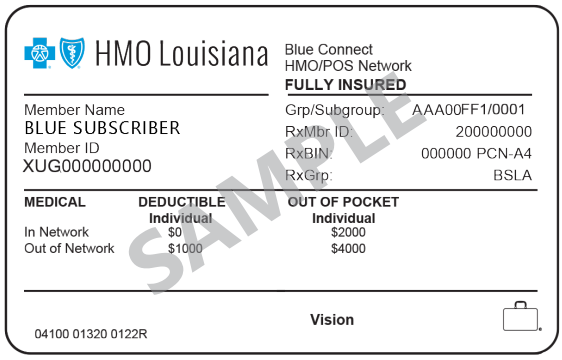
When HMO Louisiana members arrive at your office, be sure to ask them for their current HMO Louisiana member ID card. The main identifier for these members is the HMO Louisiana logo in the top left corner of the card, which also indicate the product type as either an HMO Plan or Point of Service (POS) Plan. HMO Louisiana members carry an ID card similar to the one shown here. ID cards are issued with the same member ID number for each covered member.



BLUE CONNECT

Blue Connect is an HMO-POS select network product available to groups and individuals in:

- Lafayette Area: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes
- New Orleans Area: Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes
- Shreveport Area: Bossier and Caddo parishes



Members with Blue Connect may choose each time they need care whether to use a network provider or go out-of-network. Tiered benefits apply to members of Blue Connect. More details about this coverage can be found in iLinkBlue.

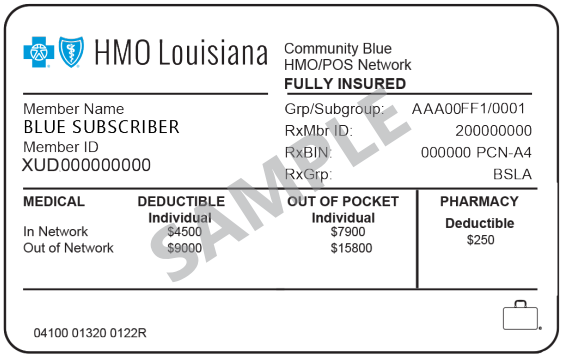
Members receive the highest level of benefits when using network providers and with proper authorization when required. Members receive a lower level of benefits when using providers not in the Blue Connect network. Fully insured Blue Connect members must select a primary care provider. The Blue Connect network name on the member ID card identifies the member as participating in this network.

Please Note: While the Blue Connect product is offered in the Lafayette, New Orleans and Shreveport areas only, Blue Connect members may still access Blue Connect network providers located in other parishes.

COMMUNITY BLUE

Community Blue is an HMO-POS select network product available to groups and individuals in the:

- Baton Rouge Area: Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

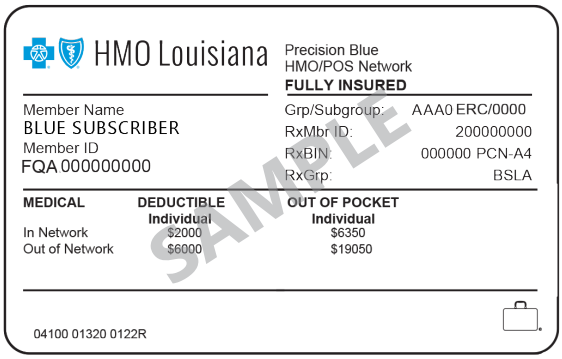


Members may choose each time they need care whether to use a network provider or go out-of-network. Tiered benefits apply to members of Community Blue. More details about this coverage can be found in iLinkBlue. Members receive the highest level of benefits when using network providers and with proper authorization when required. Members receive a lower level of benefits when using providers not in the Community Blue network. Fully insured Community Blue members must select a primary care provider. The Community Blue network name on the member ID card identifies the member as participating in this network.

PRECISION BLUE

Precision Blue is an HMO-POS select network product available to groups and individuals in the:

- Baton Rouge Area: Ascension, East Baton Rouge, Livingston, Pointe Coupee and West Baton Rouge parishes
- Greater Monroe/West Monroe Area: Caldwell, Morehouse, Ouachita, Richland and Union parishes



Members may choose each time they need care whether to use a network provider or go out-of-network. Tiered benefits apply to members of Precision Blue. More details about this coverage can be found in iLinkBlue. Members receive the highest level of benefits when using network providers and with proper authorization when required. In-network benefits will apply to Enhanced Tier 1 and Tier 1 Precision Blue network providers. Enhanced Tier 1 providers may have a lower member cost share for primary care provider and specialist office visits. Facilities are not included in Enhanced Tier 1.

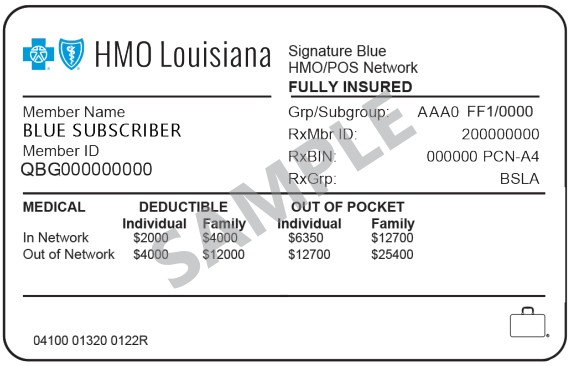
Members receive a lower level of benefits when using providers not in the Precision Blue network. Fully insured Precision Blue members must select a primary care provider. The Precision Blue network name on the member ID card identifies the member as participating in this network.

SIGNATURE BLUE

Signature Blue is an HMO-POS select network product available to groups and individuals in the:

- New Orleans Area: Jefferson, Orleans and St. Tammany parishes

Tiered benefits apply to members of Signature Blue. More details about this coverage can be found in iLinkBlue. Members receive the highest level of benefits when using network providers and with proper authorization when required.



Members receive a lower level of benefits when using providers not in the Signature Blue network. Fully insured Signature Blue members must select a primary care provider. The Signature Blue network name on the member ID card identifies the member as participating in this network.

TIERED BENEFITS FOR SELECT NETWORKS

There are different benefit tiers for members in our select networks. Please always verify the member's eligibility, benefits and limitations prior to rendering services. To do this, use iLinkBlue.

When researching coverage for a member with Blue Connect, Community Blue, Precision Blue or Signature Blue, you will see tiered benefit requirements on the Medical Benefits Summary page in iLinkBlue. The provider must participate in the member-patient's specific select network to be considered a Tier 1 provider for that member.

Please Note: Precision Blue will identify four benefit tiers for members and will only apply in-network benefits to Enhanced Tier 1 and Tier 1 providers. The other select networks will identify three benefit tiers and will only apply in-network benefits to a Tier 1 provider.

Enhanced Tier 1 In Network Preferred

For Precision Blue only: Applies to select providers in the Precision Blue network.

Example Scenario:

- A Precision Blue member sees a select Precision Blue network provider.
- The member accumulations and copayments identified for Enhanced Tier 1 should be applied.
- Provider may not bill the member for any amount over the allowed amount.

Tier 1 In Network Preferred

Applies to providers participating in the member's specific network.

Example Scenario:

- A Community Blue member sees a Community Blue network provider.
- The member accumulations, copayments and coinsurance identified for Tier 1 should be applied.
- Provider may not bill the member for any amount over the allowed amount.

Tier 2 Out of Network Preferred

Applies to providers participating in-network with Blue Cross but NOT in the member's specific network.

Example Scenario:

- A Community Blue member sees a Signature Blue network provider.
- The member accumulations, copayments and coinsurance identified for Tier 2 should be applied.
- Provider may not bill the member for any amount over the allowed amount.

Tier 3 Out of Network Non-Preferred

Applies to providers who do not participate in any Blue Cross network.

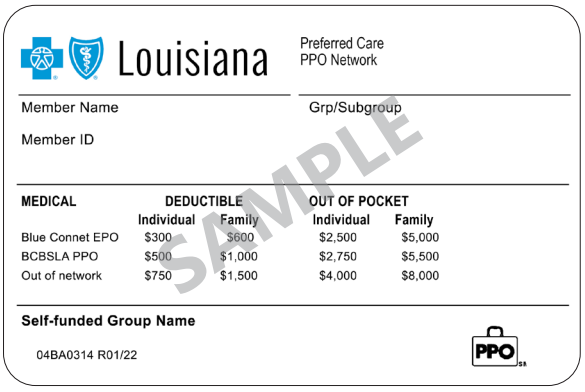
Example Scenario:

- A Community Blue member sees a non-participating provider.
- The member accumulations, copayments and coinsurance identified for Tier 3 should be applied.
- As applicable, provider may bill the member an amount over the allowed amount in accordance with pertinent state and federal law(s).

View our *iLinkBlue User Guide* for more information on researching member coverage information. It is available on our Provider page at www.bcbsla.com/providers >Resources >Manuals.

SELECT NETWORK EPO

Select network exclusive provider organization (EPO) designs are available to self-funded groups.



Tiered benefits apply to members of a select network EPO. More details about this coverage can be found in iLinkBlue.

In-network benefits will apply to Tier 1 and Tier 2 network providers. Members receive the highest level of benefits when using Tier 1 network providers and when required authorization of services is obtained. The provider must participate in the member-patient's specific select network to be considered a Tier 1 provider for that member. Preferred Care PPO providers are considered as in-network Tier 2 providers for members of a select network EPO.

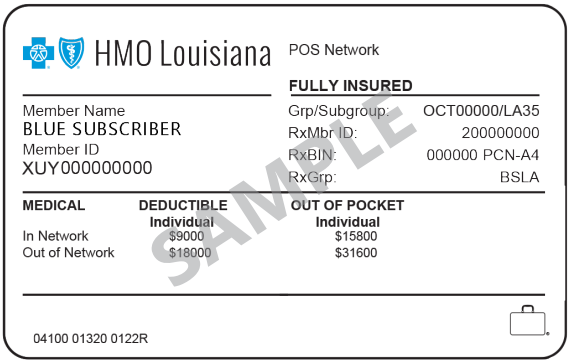
The member ID card identifies a self-funded group member as participating in a select network EPO under the medical deductible and out of pocket information.

We offer four select network EPO variations:

- Blue Connect EPO - accesses Blue Connect network providers for Tier 1 benefits
- Community Blue EPO - accesses Community Blue network providers for Tier 1 benefits
- Precision Blue EPO - accesses Precision Blue network providers for Tier 1 benefits
- Signature Blue EPO - accesses Signature Blue network providers for Tier 1 benefits

BRIDGE BLUE SHORT-TERM MEDICAL

Customers can enroll for Blue Cross and HMO Louisiana individual medical policies through the healthcare marketplace (the exchange) or buy off-exchange policies during open enrollment only, for a January 1 effective date. Once open enrollment ends, these customers are unable to purchase individual policies until the next open enrollment period. HMO Louisiana offers individual short-term medical (STM) policies to qualifying customers. We accept applications anytime throughout the year.



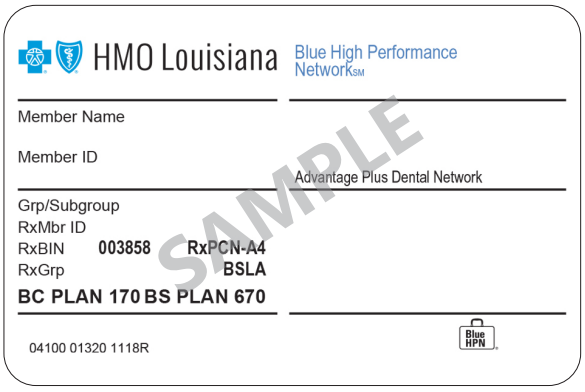
Members may carry up to 11 months of coverage with underwriting approval. These policies may be renewed. Individuals can maintain healthcare coverage until the next open enrollment in the marketplace. Exclusions and limitations apply for these STM policies.

We offer four individual benefits products:

- Bridge Blue POS - accesses the HMO Louisiana network
- Bridge Community Blue POS - accesses the Community Blue network
- Bridge Blue Connect POS - accesses the Blue Connect network
- Bridge Precision Blue POS - accesses the Precision Blue network

BLUE HIGH PERFORMANCE NETWORK

Blue High Performance Network$_{SM}$ (BlueHPN) is a national network focused on enhancing the quality of care and delivery of cost savings to large self-funded employer groups. This network allows eligible employer groups with employees located throughout the country seamless access to a quality and affordable healthcare network nationwide.



HMO Louisiana, Inc. offers a BlueHPN network and member benefit option. Our BlueHPN members have access to other providers participating in the BlueHPN network across the nation.

BlueHPN members must access BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for services provided to BlueHPN members according to the BlueHPN contract with BCBSLA.

BlueHPN is an Exclusive Provider Organization (EPO). This means benefits are only covered for care by in-network providers. It is important to note that for non-BlueHPN providers, benefits for services incurred are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas. Benefit limitations are included on the back of the BlueHPN member ID card. If you are a non-BlueHPN provider but participate in the Preferred Care PPO network, you will be reimbursed for services provided to BlueHPN members according to your PPO allowable charges.

BlueHPN members are recognizable by:

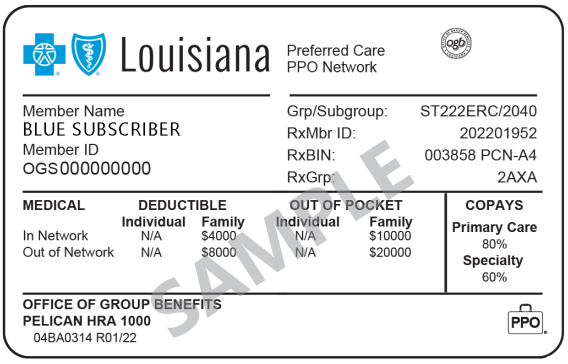
- The Blue High Performance Network name on the front of the member ID card.
- The BlueHPN in a suitcase logo in the bottom right hand corner of the member ID card.

OFFICE OF GROUP BENEFITS (OGB) BENEFIT PLANS

Blue Cross and Blue Shield of Louisiana administers benefits for the Office of Group Benefits (OGB) state of Louisiana employees, retirees and dependents. Five benefit plans are available: Pelican HRA 1000, Pelican HSA 775, Magnolia Local, Magnolia Local Plus and Magnolia Open Access. These products are plans that use our networks of doctors, hospitals and other medical care providers, as well as Blue providers nationwide.

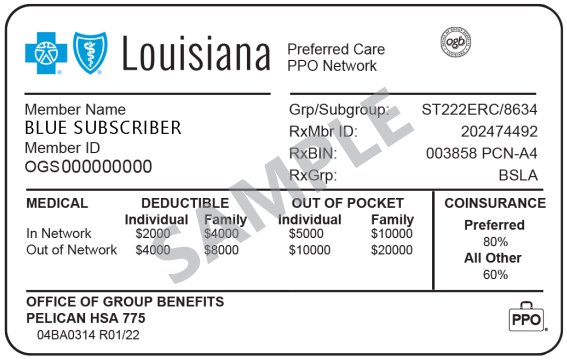
Pelican HRA 1000 (active employees & retirees with and without Medicare)

This is a consumer-driven benefit plan (CDHP) paired with a health reimbursement arrangement (HRA). This benefit plan uses the OGB Preferred Care network, which is Blue Cross' Preferred Care PPO provider network.



Pelican HSA 775 (active employees only)

This is a consumer-driven benefit plan that is paired with a health savings account (HSA) option. The Pelican HSA 775 benefit plan uses the OGB Preferred Care Network, which is Blue Cross' Preferred Care PPO provider network.

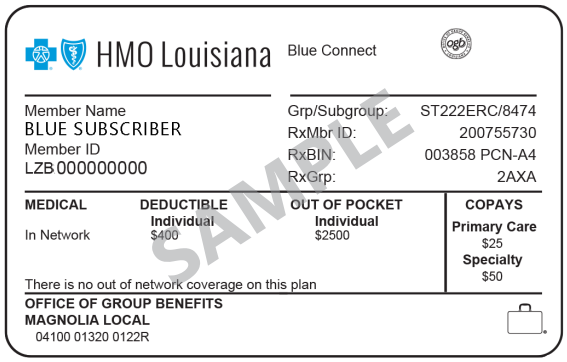


Magnolia Local (active employees & retirees with and without Medicare)

This benefit plan uses our Blue Connect or Community Blue provider network. Magnolia Local is an HMO Point of Service product that allows members to choose each time they need care—at the point of service—whether to use a primary care provider (PCP) or a specialist without a referral. This benefit plan is only available as follows:

<u>Blue Connect network</u>

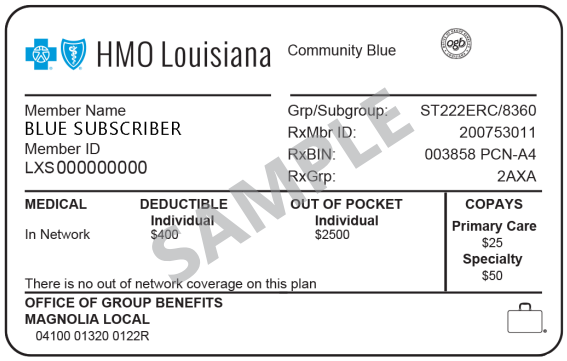
- Lafayette Area: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary and Vermilion parishes
- New Orleans Area: Jefferson, Orleans Plaquemines, St. Bernard, St. Charles, St. John the Baptist and St. Tammany parishes
- Shreveport Area: Bossier and Caddo parishes



Community Blue network

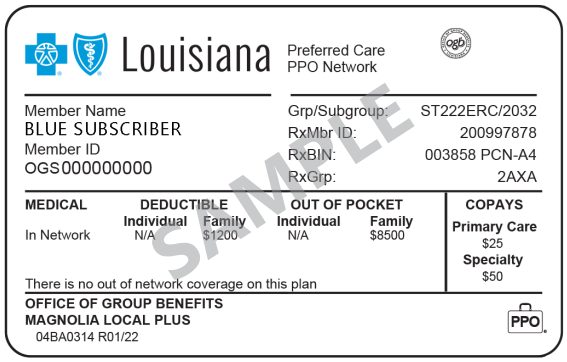
- Baton Rouge Area: Ascension, East Baton Rouge, Livingston and West Baton Rouge parishes

Magnolia Local members in Blue Connect parishes do not have coverage if they choose to see Community Blue providers, just as Magnolia Local members in the Community Blue parishes do not have coverage if they choose to see Blue Connect providers. With this benefit plan, there is no coverage for services performed by non-network providers. Please refer your patients to providers within their network to ensure they receive the highest level of benefits available.



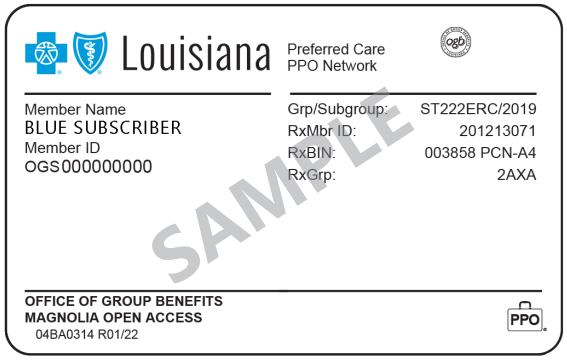
Magnolia Local Plus (active employees & retirees with and without Medicare)

This benefit plan has an HMO benefit design but through a PPO network. Members with this benefit plan are not limited to a local-area only network. Members who choose the Magnolia Local Plus benefit plan have access to the OGB Preferred Care network, which is Blue Cross' statewide Preferred Care PPO network. With this benefit plan, there is no coverage for services performed by non-network providers.



Magnolia Open Access (active employees & retirees with and without Medicare)

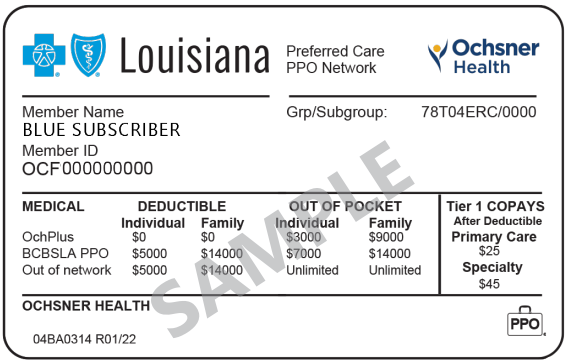
This benefit plan is OGB's PPO benefit plan. Members with this benefit plan have access to the OGB Preferred Care PPO network.



OCHPLUS

The OchPlus Network consists of a select group of physicians, hospitals and other allied providers that service Ochsner Clinic Foundation or Southern Regional Medical Corporation employees.

Some OchPlus Network providers are contracted for limited services only. Please refer OchPlus Network members to providers within the network so they receive the highest level of benefits.



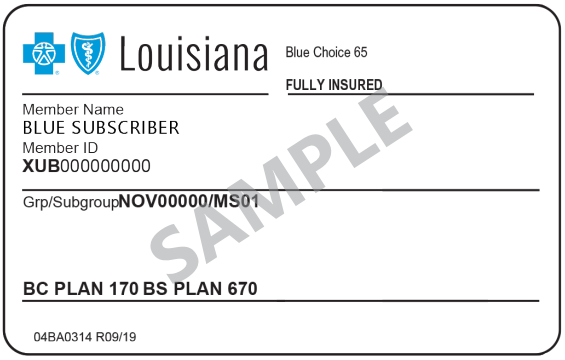
The Ochsner Health name and logo on the member ID card identifies the member as participating in this network.

BLUECHOICE 65

BlueChoice 65 is a series of Medicare supplement plans and are designed to pay for many of the expenses Medicare does not pay. Some of the options in this series include:

- Part A deductible coverage
- Part B deductible coverage, coinsurance and excess charges
- Skilled nursing coinsurance

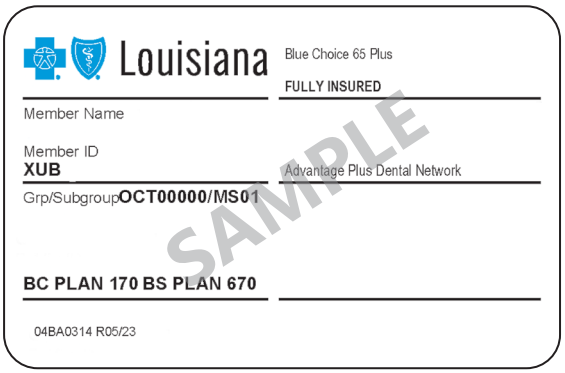
Fully insured BlueChoice 65 members must select a primary care provider.



BlueChoice 65 PLUS

BlueChoice 65 PLUS provides the same benefits as BlueChoice 65, with the addition of Plan G dental benefits.

Fully insured BlueChoice 65 PLUS members must select a primary care provider.

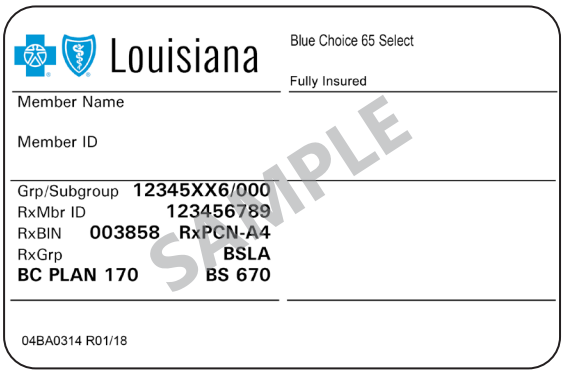


BlueChoice 65 SELECT

BlueChoice 65 SELECT plans feature lower premiums and a select network of hospitals that have agreed to waive the Part A deductible and coinsurance.

Note: BlueChoice 65 refers to certain contracts and is not connected with or endorsed by the U.S. government or the federal Medicare program.

Fully insured BlueChoice 65 SELECT members must select a primary care provider.

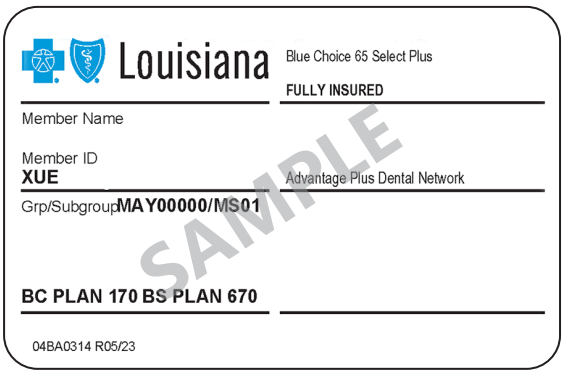


BlueChoice 65 SELECT PLUS

BlueChoice 65 SELECT PLUS features the same benefits as BlueChoice 65 SELECT, with the addition of Plan G dental benefits.

Note: BlueChoice 65 SELECT PLUS refers to certain contracts and is not connected with or endorsed by the U.S. government or the federal Medicare program.

Fully insured BlueChoice 65 SELECT PLUS members must select a primary care provider.



NATIONAL ALLIANCE

Blue Cross and Blue Shield of Louisiana (BCBSLA) has several self-funded groups with unique member benefit plans. For these benefits, we are partnered with Blue Cross and Blue Shield of South Carolina (BCBSSC) and use their National Alliance program to administer services.

For more on this member benefit product, please refer to our Identification Card Guide provider tidbit available on our Provider page at www.bcbsla.com/providers >Resources >Tidbits.

A complete listing of our National Alliance groups and prefixes is available on iLinkBlue (www.bcbsla.com/ilinkblue) under the "Resources" section.

BLUECARD PROGRAM

The BlueCard® Program links participating providers and the independent Blue Cross and Blue Shield (BCBS) Plans across the country and abroad with a single electronic network for professional, outpatient and inpatient claims processing and reimbursement. The program allows BCBS participating providers in every state to submit claims for members who are enrolled through another Blue Plan to their local BCBS Plan.

You should submit claims for BCBS members (including Blue Cross only and Blue Shield only) visiting you from other areas directly to Blue Cross and Blue Shield of Louisiana. Blue Cross and Blue Shield of Louisiana is your sole contact for all BCBS claims submissions, payments, adjustments, services and inquiries.

Please Note: Providers should follow the guidelines set forth in this manual and those that are included in the *BlueCard Program Provider Manual*, which is a supplement to this office manual and is located on our Provider page.

How to Identify BlueCard Members

When members from other Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the prefix, a blank suitcase logo, and for eligible PPO members, the "PPO in a suitcase" logo.

A correct member identification number includes the three-character prefix in the first three positions and all subsequent characters up to a total of 17 positions. Some member identification numbers may include alphabetic characters within the body of the number. These alphabetic characters are part of the member's identification number and are not considered to be part of the three-character prefix.

Member ID Prefixes

The three-character prefix at the beginning of the member's ID number is the key element used to identify and correctly route out-of-area claims. It is also critical for confirming a patient's membership and coverage. The prefix identifies the Blue Plan or national account to which the member belongs.

It is very important to capture all identification card data at the time of service. If the information is not captured correctly, you may experience a delay in claims processing. We suggest that you always make copies of the front and back of the member ID cards and pass this key information on to your billing staff and any other providers you refer the member to, for example, lab, X-ray, etc. Do not make up prefixes.

Do not assume that the member ID number is a Social Security number. All Blue Plans replaced Social Security numbers on member ID cards with alternate, unique identifiers.

Member ID Cards with no Prefix

Some member ID cards may not have a prefix or suitcase logo, which may indicate that claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the card for how to file claims. If that information is not available, call the customer service number indicated on the member ID card.

"Suitcase" Logo

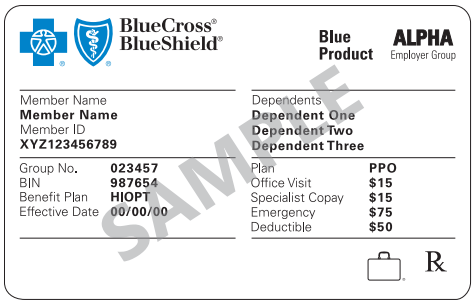
A blank "suitcase" logo on a member ID card indicates that the member has Blue Cross and Blue Shield Traditional, POS or HMO benefits delivered through the BlueCard Program.

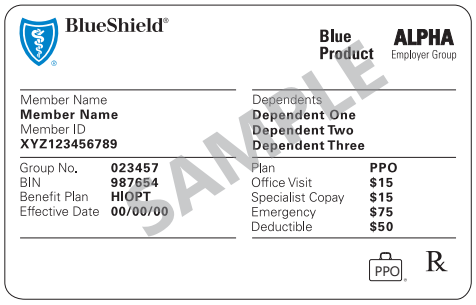
The PPO suitcase indicates the member is enrolled in a Blue Plan's PPO or EPO product.

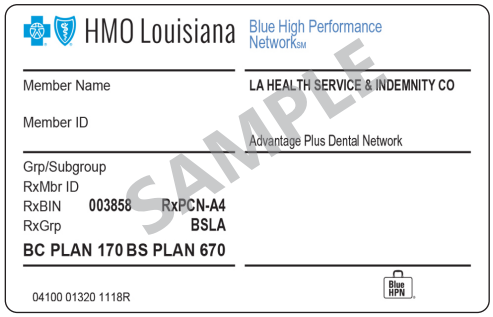
The PPOB suitcase indicates the member has access to the exchange PPO network, referred to as BlueCard PPO basic.

The empty suitcase indicates the member is enrolled in a Blue Plan's traditional, HMO, POS or limited benefits product.

The BlueHPN suitcase logo indicates the member is enrolled in a Blue High Performance Network (BlueHPN) or BlueHPN EPO product.







HMO Patients Serviced Through the BlueCard Program

In some cases, you may see BCBS HMO members affiliated with other BCBS Plans seeking care at your facility. You should handle claims for these members the same way you handle claims for Blue Cross and Blue Shield of Louisiana members and BCBS PPO patients from other Blue Plans—by submitting them through the BlueCard Program. Members are identified by the "empty suitcase" logo on their ID card.

BlueCard members throughout the country have access to information about participating providers through BlueCard Access, a nationwide toll-free number (1-800-810-2583). Members call this number to find out about BlueCard providers in another Blue Plan's service area. You can also use this number to get information on participating providers in another Blue Plan's service area.

How the Program Works

1. You may verify the patient's coverage on iLinkBlue or by calling BlueCard Eligibility® Line. An operator will ask you for the prefix on the member ID card and will connect you to the appropriate membership and coverage unit at the member's Blue Plan. If you are unable to locate a prefix on the member ID card, check for a phone number on the back of the member ID card, and if that is not available, call the Customer Care Center.

2. After you render services to a BCBS member, you should file the claim (according to your contractual arrangements) with Blue Cross and Blue Shield of Louisiana.
   Please Note: The claim must be filed using the three-character prefix and identification number located on the member ID card.

3. Once the claim is received, Blue Cross and Blue Shield of Louisiana electronically routes it to the member's Blue Plan.

4. The member's Blue Plan applies benefits, adjudicates the claim and transmits it back to Blue Cross and Blue Shield of Louisiana, either approving or denying payment. The processing time of the claim may take longer than most Blue Cross processes. In the event that the member's Blue Plan approves payments, payment to you is based on the applicable allowable rates from Blue Cross and Blue Shield of Louisiana and the limitations of the member's benefit plan.

5. Blue Cross and Blue Shield of Louisiana reconciles payment and forwards it to you according to your payment cycle.

6. The member's Blue Plan sends a detailed explanation of benefits (EOB) report to the member.

Types of Claims Filed Through the BlueCard Program

All professional claims as well as facility inpatient and outpatient claims for BlueCard members should be filed to Blue Cross and Blue Shield of Louisiana. Medicare primary could be paid differently by each Blue plan. Blue Cross and Blue Shield of Louisiana pays according to the member's participation with us and their participation with Medicare. If the member is of Medicare age and does not indicate that Medicare is primary, we will pay as if Blue Cross is primary.

The Federal Employee Program (FEP) and other Blue Cross plans will pay according to the member's contract language. However, if it is determined that the member should have been set up initially with Medicare as primary, the provider will be asked to return any reimbursement and the claim will have to be reprocessed with Medicare as primary.

Ancillary Claims Filing Instructions for BlueCard Claims

Ancillary claims for Independent Clinical Laboratory, Durable/Home Medical Equipment and Supply, and Specialty Pharmacy are filed to the Local Plan in whose service area the ancillary services were rendered—if these services were performed in Louisiana, the Local Plan is Blue Cross and Blue Shield of Louisiana.

- Independent Clinical Laboratory: Local plan is the plan in whose service area the specimen is drawn. This is determined by the state where the referring physician is located.
- Durable/Home Medical Equipment (DME/HME): Local Plan is the plan in whose service area the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy: Local Plan is the plan in whose service area the ordering physician is located.

Please Note: Complete instructions on filing ancillary claims for BlueCard members are included in *The BlueCard® Program Manual*, which is a supplement to this office manual and is located on our Provider page.

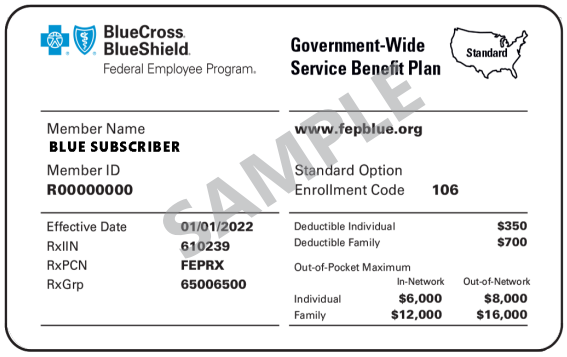
FEDERAL EMPLOYEE PROGRAM (FEP)

The Federal Employee Program (FEP) provides benefits to federal employees and their dependents. These members access the Preferred Care PPO Network.

FEP members have three benefit plans to choose from: FEP Standard Option, FEP Basic Option or FEP Blue Focus. Under FEP Standard Option, members receive the highest level of benefits when they receive care from network providers and reduced benefits when they receive care from out-of-network providers. Members with FEP Basic Option and FEP Blue Focus have no benefits when they receive care from out-of-network providers, except for select situations such as emergency care.

FEP Standard Option

With FEP Standard Option, members do not need referrals for any provider, including out-of-network providers. However, if a member chooses to use non-Preferred Care PPO providers, their out-of-pocket expenses will be greater.



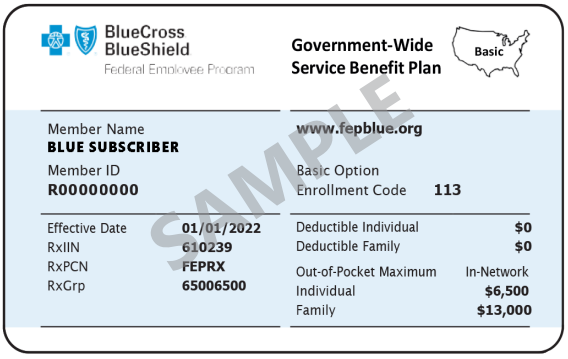
Office Visits: Members have a $25 copayment when they see a PCP. If members go to a specialist, they have a $35 copayment for the office visit.

Preventive Care Services: Members are covered at 100% for covered preventive services performed by preferred providers.

Maternity Care: Members pay nothing for covered physician and hospital services related to maternity care when they use Preferred Care PPO providers.

FEP Basic Option

With the FEP Basic Option, members must use preferred providers for all their medical care. Benefits are only available for care provided by out-of-network providers in certain situations, such as emergency care. With FEP Basic Option, there is no calendar year deductible. FEP Basic Option benefits are paid in full or in full after members pay a copayment amount when they use Preferred Care PPO providers.



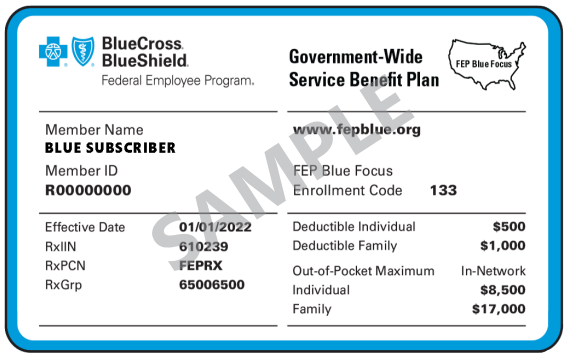
Office Visits: Members have a $30 copayment for office visits to PCPs. If members go to a specialist, they pay $40 for the office visit.

Preventive Care Services: Members are covered at 100% for covered preventive services performed by preferred providers. During these visits, members are also covered at 100% for many preventive services such as mammograms, sigmoidoscopies, Pap smears, prostate and colorectal cancer screenings. Preventive care benefits are limited to one per calendar year.

Maternity Care: Members pay nothing for covered prenatal and postnatal care rendered by a Preferred Care PPO provider. Benefits for the inpatient hospital admission to a Preferred Care PPO hospital for the delivery are paid in full, after the member pays a $175 copayment.

FEP Blue Focus

With FEP Blue Focus, members must use preferred providers for all their medical care. Benefits are only available for care provided by out-of-network providers in certain situations, such as emergency care. With FEP Blue Focus, there is a $500 calendar year deductible.



Office Visits: Members have a $10 copayment per visit for the first 10 office visits (PCP and/or specialist) per calendar year. All subsequent office visits are subject to deductible and coinsurance, as applicable.

Preventive Care Services: Members are covered at 100% for covered preventive services performed by preferred providers.

Maternity Care: Members pay nothing for covered prenatal and postnatal care rendered by a Preferred Care PPO provider. Benefits for the inpatient hospital admission to a Preferred Care PPO hospital for the delivery are paid in full, after the member pays a $1,500 copayment.

Cancer Screening

There are no age or frequency limitations applicable to covered cancer screenings.

Provider Tips

- Determine the member's financial responsibility by viewing member benefits on iLinkBlue.
- Ask members for their ID card regularly.
- First check eligibility and benefits through iLinkBlue.

FEP Non-network or No Network Claims Processing

Blue Cross pays FEP members directly for all services performed by any provider who does not have an agreement with us.

There are two classifications of non-contracted providers:

1. A non-participating provider is defined as one that has chosen not to sign a network agreement with Blue Cross.

2. A non-network or no network provider is a provider/specialty type that Blue Cross does not offer network agreements to.

Please Note: An out-of-network provider is defined as a provider that has signed a network agreement with Blue Cross but is not in the specific network tied to the member's benefit.

CONSUMER-DIRECTED HEALTHCARE

Consumer-directed healthcare (CDHC) is a movement in the healthcare industry designed to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make informed and appropriate healthcare decisions through the use of member support tools, provider and network information, and financial incentives. CDHC includes many different benefit plans and services including consumer-directed health plans (CDHP), high deductible health plans and the option to use debit cards for payment. In conjunction with these plans, members may have a health reimbursement account (HRA), health savings account (HSA) or flexible spending account (FSA).

When the consumer is paying more of the bill, you may need to devote resources to conducting pre-service work with patients. Consumers on a high deductible health plan may require more specialized service work due to the questions on cost and options.

When the Consumer Is Paying More of the Bill			
Sales/Marketing Fulfillment	Pre-Service	At Point of Service	Post-Service
• Seeks education about choices. • Selects health plan. • Selects network/ providers.	• Seeks information. • Estimates costs to compare providers and treatment options. • Seeks quality information about providers.	• Knows what they owe. • Can apply payment from a variety of sources, including access to credit.	• Seeks help with next steps of treatment plan: - Health information/ coaching - Efficient sources
• Promotion to consumers. • Performance information for consumers.	• Determines member eligibility and benefits. • May estimate member responsibility for upcoming service. • May inform member of estimate in advance.	• Determines eligibility, benefits and specific member responsibility. • Collects correct amount from the source selected by the member.	• Provides feedback on performance. • Seeks improvements: - Administrative - Clinical

Consumer Directed Health Plans

High-deductible health plans (HDHPs) partnered with member personal savings accounts (PSAs)—such as an HSA, an HRA, or a FSA—form a CDHP. The type of account used in these arrangements has strong implications to the administration of the CDHP, as the IRS regulations governing these tax-favored PSAs vary significantly.

Once members have met their deductible, covered expenses are paid based on the member's benefit plan. As a participating provider, you should treat these members just as you would any other Blue Cross member:

- You should accept the Blue Cross reimbursement amount/allowable charge (up to the member's deductible amount) and any coinsurance amount, if applicable, as payment in full.

- If you collect billed charges up front, you must refund the member the difference between your charge and the Blue Cross reimbursement amount/allowable charge within 30 days.

Examples of what to collect from members:		
1) Member's Total Deductible	$2000	
Member's Deductible Applied	$2000	
Allowable Charge	$ 100	**Member Has Met Deductible**
Amount to be collected from member	**$ 0**	
Blue Cross Pays	$ 100	
2) Member's Total Deductible	$2000	
Member's Deductible Applied	$1000	**Member Has NOT Met Deductible**
Allowable Charge	$ 100	
Amount to be collected from member	**$ 100**	
3) Member's Total Deductible	$2000	
Member's Deductible Applied	$2000	
Allowable Charge	$ 100	**Member with Coinsurance**
Member's Coinsurance (20%)	$ 20	
Amount to be collected from member	**$ 20**	
Blue Cross Pays	$ 80	

BlueCard members whose plan includes a debit card can pay for out-of-pocket expenses by swiping the card through any debit card swipe terminal. These cards are used just like any other debit card. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account. If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to accept any other signature debit card.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their debit cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.

Blue*Saver* Claims Filing Tips

Below are some helpful tips that will guide you when processing claims for and payments from Blue members with a CDHP like Blue*Saver*:

- Commit to pre-service work with patients. Contact to confirm appointment and ask them to bring a copy of their current member ID card. Offer to discuss out-of-pocket expenses prior to their visit.
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Verify the member's eligibility or benefits through iLinkBlue and provide the prefix, or use electronic capabilities.
- Carefully determine the member's financial responsibility before processing payment.

- If the member presents an HSA or HRA debit card or debit/ID card, be sure to verify the member's cost sharing or out-of-pocket amount before processing payment.
- Please do not use the card to process full payment up front.
- File claims for all members with CDHPs (including those with BlueCard) to Blue Cross.

Please Note: If you have any questions about the health care debit card processing instructions or payment issues, please contact the debit card administrator's toll-free number on the back of the card.

Members with Consumer Directed Health Plans Like Blue*Saver*

Many consumer directed healthcare (CDHC) members carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Some cards are "stand-alone" debit cards that cover out-of-pocket costs, while others also serve as a member ID card and include the member ID number. The combined card will have a nationally recognized Blue logo, along with the logo from a major debit card company such as MasterCard® or Visa®.

Members can use their cards to pay outstanding balances on billing statements. If your facility currently accepts credit card payments, there is no additional equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit cards.

If the member presents a debit card (stand-alone or combined), be sure to verify the member's cost share amount before processing payment. Do not use the card to process full payment up front.

Please Note: If you have questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Blue adVantage (HMO) and Blue adVantage (PPO)

Blue Advantage is our Medicare Advantage product. For information to aid you in servicing members with Blue Advantage healthcare benefits, please refer to the *Blue Advantage Provider Administrative Manual*. It is located on the Blue Advantage Provider Portal, available through iLinkBlue.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, an independent licensee of the Blue Cross Blue Shield Association, offers Blue Advantage (PPO).

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

Blue Advantage (HMO) Dual Plus

Blue Advantage Dual Plus (HMO-POS D-SNP) is a Blue Advantage (HMO) product and available to our members with a dual coverage (Medicaid and Medicare Advantage) special needs product (SNP). It includes the prefix MDV. It is available to Blue Advantage (HMO) members who are also eligible for Medicaid.

MEDICARE ADVANTAGE MEMBERS FROM OTHER BLUE PLANS

For information to aid you in servicing Medicare Advantage members from other Blue plans, please refer to *The BlueCard® Program Provider Manual,* available online on our Provider page.

HEALTHY BLUE AND HEALTHY BLUE DUAL ADVANTAGE

We offer consumers in Louisiana two Healthy Blue options of coverage:

Healthy Blue

This is our Medicaid product designed to help consumers eligible for Medicaid or LaCHIP get healthcare coverage. Members are eligible for all covered services including physical health and mental health services.

Healthy Blue Dual Advantage (HMO D-SNP)

Healthy Blue Dual Advantage is our dual coverage (Medicaid and Medicare Advantage) special needs product (SNP). It is available to Blue Advantage members who are also eligible for Medicaid. Healthy Blue Dual Advantage includes supplemental benefits for items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the plan in addition to what Medicare covers.

Healthy Blue and Healthy Blue Dual Advantage (HMO D-SNP) are managed by Elevance Health, on behalf of Blue Cross and Blue Shield of Louisiana. For more information, go to https://providers.healthybluela.com.

For more on this member benefit product, please refer to our Identification Card Guide provider tidbit available on our Provider page at www.bcbsla.com/providers >Resources >Tidbits.