BC65 MEDICARE | PLAN G SELECT

Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company.

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BlueChoice 65

MEDICARE SUPPLEMENTAL POLICY

STANDARDIZED BENEFIT PLAN G SELECT

GUARANTEED RENEWABLE

This policy is automatically guaranteed renewable, subject to all the terms and provisions of the policy and upon payment of premiums when due. No pre-existing condition limitation or waiting periods are part of this policy.

CONTINUATION OF COVERAGE AND CHANGES IN PREMIUM

You may continue this policy in effect for as long as You live. To continue coverage, pay the premium when due at the intervals available to you. You must pay the premium by its due date or during the thirty (30) days that follow.

We may change the premium for this policy. Since benefits are tied to Medicare's Deductible, Coinsurance and copayment amounts and limits, premium and benefit changes are expected to occur each year. The change may also be due to a new table of rates or a change in Medicare's benefit structure, an increase in Your age, a change in geographic location, or an increase in the policy benefit level. You will be notified at least 45 days before any premium increase.

YOUR THIRTY (30) DAY RIGHT TO RETURN THE POLICY

If you are not satisfied with this policy, You may return it to Us within thirty (30) days after you receive it. We will refund to you any premium paid and the policy will be void.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES. THIS POLICY IS RENEWABLE FOR LIFE. PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR.

provided **by**

Louisiana

P.O. Box 98029 · Baton Rouge, Louisiana · 70898-9029

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I. Steven Udvarhelyi, M. D.
President and Chief Executive Officer

Louisiana Health Service & Indemnity Company
Blue Cross and Blue Shield of Louisiana Incorporated as Louisiana Health Service & Indemnity Company

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This Blue Choice 65 Select policy is a Medicare Supplement policy and is a Contract between You and the Louisiana Health Service & Indemnity Company (hereinafter called "Blue Cross and Blue Shield of Louisiana"). When We enter into this Contract with You, We agree to provide to You the benefits described in the policy, as long as the policy is in effect.

In this policy the words "We," "Us," "Our," and "the Company" mean Blue Cross and Blue Shield of Louisiana. The words "You", "Your", "Insured" and "Policyholder" refer to You as the person covered by the policy.

Your Blue Choice 65 Select Medicare Supplement policy is designed to work together with Your Medicare coverage by paying many of Your medical expenses which are not fully paid by Medicare.

Knowledge of how Medicare pays will help You better understand how Your Blue Choice 65 Select Medicare Supplement policy works. Medicare does not pay for all health care services. When Medicare does pay, it usually does not pay the bill in full. The difference may be a Deductible, Copayment or Coinsurance, excess charges (the difference between charges as billed and the Medicare "approved amount"), and other non-covered items. You are responsible for these and must see that they are paid. The purpose of Your Blue Choice 65 Select Medicare Supplement policy is to help You pay a portion of these charges.

CONSIDERATION

We issued this policy in consideration of the application and payment of the premium. Timely payment of the premium will keep the policy in effect. Please read the copy of the application which is a part of this policy.

SUSPENSION AVAILABLE

If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify Us and request a suspension, We will suspend benefits and premiums for You for the period of Medicaid entitlement, not to exceed twenty-four (24) months (suspension period).

Suspension of policy benefits and premiums will begin from the date of Your Medicaid entitlement. Upon receipt of timely notice, We will refund any premium paid covering a period beyond the date of entitlement for Medicaid, subject to adjustment of paid claims.

If You lose entitlement to Medicaid benefits during the suspension period and notify Us within ninety (90) days, then, effective the date Medicaid entitlement terminated, We will automatically reinstitute this Blue Choice 65 Select Medicare Supplement policy coverage (with no pre-existing condition limitation or waiting period) upon payment of the required premium.

Benefits and premiums under the policy shall be suspended (for the period that may be provided by federal regulation) at the request of the Policyholder if the Policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the Policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of enrollment in the group health plan.

The reinstitution of coverage described in this section:

(a) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(b) shall provide a premium at least as favorable as would have applied had coverage not been suspended.

ARTICLE I. DEFINITIONS

Accident, Accidental Injury, or Accidental Means – Injury or injuries for which benefits are provided means accidental bodily injury sustained by the Insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this insurance coverage is in force.

Allowable Charge – the lesser of the billed charge or the amount established by Us or negotiated as the maximum amount allowed for all provider services covered under the terms of this Contract.

Benefit Period – the time used to measure in-patient Hospital or Skilled Nursing Facility (SNF) benefits for expenses covered by Medicare. It begins after the Original Effective Date with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

Blue Choice 65 Select policy - a Medicare supplement policy or certificate that contains restricted network provisions.

Calendar Year – the period beginning on the Original Effective Date and ending December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

Coinsurance – the portion of Medicare Eligible Expenses, other than a Deductible, which Medicare does not pay and which must be paid by You. The Coinsurance amounts may change on January 1 each year.

Contract – this policy plus Your application for coverage, including any endorsements created and approved to be a part of this policy, the Schedule of Benefits if any and any future changes approved according to law.

Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility – A facility defined as such and approved for payment as such by Medicare.

Copayment – the portion of Medicare Eligible Expenses, other than Deductible and Coinsurance, which Medicare does not pay and which must be paid by You. The Copayment amounts may change on January 1 each year.

Deductible – the portion of Medicare Eligible Expenses which You must pay during a Benefit Period before inpatient Hospital claims (Medicare Part A) are paid by Medicare and which You must pay during the Calendar Year before medical claims (Medicare Part B) are paid by Medicare. The amounts of the Medicare Deductibles may change on January 1 each year.

Emergency or Life Threatening Illness - the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical care could reasonable result in: (1) permanently placing the patient's health in jeopardy; (2) serious impairment of bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences; or (4) for which death is probable. Some examples of Emergencies include, but are not limited to the following: unusual or excessive bleeding; serious burns; poisoning; unconsciousness; and convulsions.

Health Care Expenses – for purposes of the requirements of LA Regulation 33, Section 545, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

Hospital – a place which is defined as a Hospital and approved for payment as a Hospital by Medicare.

Medicaid – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources pursuant to Title XIX of the Social Security Amendments of 1965, as then constituted or later amended

Medicare – the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses – expenses of the kinds covered by Medicare Part A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part D – the prescription drug coverage provided to eligible Medicare beneficiaries pursuant to the Medicare Modernization Act of 2003 as then constituted and later amended.

Medically Necessary (or "Medical Necessity") – health care services, treatments, procedures, equipment, drugs, devices, items or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

C. not primarily for the personal comfort or convenience of the patient, Physician or other health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Network Hospital - a Hospital which has entered into a written agreement with Us to provide benefits insured under a Blue Choice 65 Select policy.
Original Effective Date – The date when Your coverage begins under this policy as determined by Us. Benefits will begin at 12:01 AM on this date.

Physician – An individual licensed under state law to practice medicine or osteopathy. It does not include You or a member of Your family unless otherwise required by Medicare.

Sickness – means illness or disease of an Insured person which first manifests itself after the Original Effective Date of insurance and while the insurance is in force.

ARTICLE II. BENEFITS

We will pay for benefits for Medicare Eligible Expenses incurred by You due to Accidental Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage is in effect. We will not duplicate benefits paid for by Medicare.

In a case of total disability, any claim for a continuous loss that begins while this policy is in effect will not be affected by the termination of this policy. However, continued benefits for such continuous loss will be conditioned upon Your continuous total disability, and are limited to the duration of the Benefit Period for Inpatient (Medicare Part A) benefits, the Calendar Year for medical (Medicare Part B) benefits, or the maximum benefits payable, whichever occurs first. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

We will pay benefits as described below as long as You have coverage under Medicare inpatient Hospital and medical insurance, and after Medicare has paid its share of the covered expense. Benefits which are designed to supplement benefits payable under Medicare Part A will be paid if You have Part A coverage and Medicare has paid benefits. Upon exhaustion of the Medicare Part A Hospital inpatient coverage, this Contract will pay Part A related benefits for three hundred sixty five (365) days as described below as if You were enrolled in Medicare Part A and Medicare Part A had paid its benefits; payment will be based upon the amount Medicare would have paid for Medicare Eligible Expenses. Benefits which are designed to supplement benefits payable under Medicare Part B will be paid if You have Part B coverage. If You are not participating in Medicare Part B, this Contract will pay Part B related benefits described below as if You were enrolled in Medicare Part B and Medicare Part B had paid its benefits; payment will be based upon the Allowable Charge for the Medicare Eligible Expenses. You should notify Us in writing immediately if Your Medicare Part A benefits exhaust or Medicare Part B coverage ends. We will not impose any limitations on benefits that are more restrictive that Medicare's limitations and restrictions.

Notice: When Your Medicare Part A Hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days. During this time the Hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

Inpatient Hospital benefits are subject to the Network Hospital restriction.

ARTICLE III. BASIC CORE BENEFIT COVERAGE

We will provide benefits as follows:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare Benefit Period. The Deductible amount, Coinsurance amounts and Coinsurance period are determined by Medicare.

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept Our Company's payment as payment in full and may not bill the insured for any balance.

4. Coverage under Medicare Part A and Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

5. Coverage for the Coinsurance amount or, in the case of Hospital outpatient department services paid under a prospective payment system, the Copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement.

   The Coinsurance and Copayment amounts are determined by Medicare.

6. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Explanation of Medicare Benefits Form – Before We can pay any benefits for expenses covered under Medicare Part A and Part B, You or the health care provider must file a claim with Medicare. In the event it is not filed electronically, We must receive the Explanation of Medicare Benefits Form. This is a form sent by Medicare's Benefit Department which shows the Medicare Eligible Expenses. Claims are usually filed electronically with Medicare by the health care provider, and then Medicare usually files the claim with Us.

ARTICLE IV. ADDITIONAL COVERAGE

We will provide benefits as follows:

Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient Hospital Deductible amount per Benefit Period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance amount from the twenty-first day through the one hundredth day in a Medicare Benefit Period for post Hospital Skilled Nursing Facility care eligible under Medicare Part A.

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary Emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year Deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, “Emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

ARTICLE V. NETWORK HOSPITAL RESTRICTION

Part A Deductible and Coinsurance benefits will not be provided for inpatient Hospital services which are rendered in a Hospital that is not a Network Hospital.

This restriction will not apply for Medicare approved services if:

A. Services are not provided in an inpatient Hospital setting; or

B. The services are provided for symptoms requiring Emergency care such as care immediately required for unforeseen illness, Injury or other condition, and for which it is not reasonable to obtain such services through a Network Hospital; or

C. Services are not available at a Network Hospital.

Full plan benefits will apply for services provided in an inpatient Hospital setting under scenarios b. and c. as above. Under any other circumstances except for Emergency services outside of the United States, when You need services in an inpatient Hospital setting, Part A Deductible and Coinsurance benefits will be provided if services are rendered at a Network Hospital.

ARTICLE VI. EXCLUSIONS

No benefits will be provided for:

1. Charges which have not been submitted to and processed by Medicare when You are participating in Medicare Parts A and/or B;

2. Charges paid or payable by Medicare;

3. Charges related to the satisfaction of the Medicare Part B Deductible;

4. Charges for medical services of a practitioner who is not a licensed Physician;

5. Charges for routine dental care;

6. Charges for outpatient prescription drugs, eyeglasses, or hearing aids, unless specifically covered under this policy;

7. Charges for services, surgery, supplies, treatment or expenses rendered or furnished before Your Original Effective Date or after Your termination date. Charges for Hospital services or supplies rendered or furnished during an admission in progress on Your Original Effective Date are not covered, regardless of whether Your admission continues after Your Original Effective Date, unless otherwise required by Medicare. Hospital benefits will be provided for an admission in progress on the date Your coverage under this policy ends, until the end of that admission, or until You have reached any benefit limitations set in this policy, whichever occurs first;

8. Charges for services, supplies, equipment, or anything else which is not described in this policy as covered;

9. Charges for which You are not required to pay;

10. Charges which are not considered Medicare Eligible Expenses, except those specifically listed as covered in this Contract. This applies during the three hundred sixty five (365) days benefit for Part A and whether or not You are participating in Medicare Part B;

11. Charges that exceed the Medicare payment amount and/or the benefits provided by this policy for Medicare Eligible Expenses, including but not limited to the Allowable Charge.

12. Charges for the Medicare Part A Deductible and Coinsurance for inpatient Hospital services provided in a non-Network Hospital, except as specified in this policy.

ARTICLE VII. GENERAL PROVISIONS

The risk We assume on this policy's Original Effective Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. Medicare's benefit structure may also change.

When Medicare changes Copayment, Deductible amounts or Coinsurance amounts or limits under its benefit structure in effect on the Original Effective Date, We will automatically change policy benefits to handle such changes.

The nature of the risk We assumed when this policy was issued may change to the extent that Medicare's benefit structure changes. If it does, We may have to change this policy's coverage. We will make such a change by: (a) adding an endorsement to the policy and/or (b) adding a new schedule page and/or (c) reissuing the policy. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Original Effective Date.

Any premium change needed because of such a benefit or structure change will be made only after We give You notice.

A. GUARANTEED ISSUE

Guaranteed issue is available to eligible persons who seek to enroll under the policy during the periods and under the circumstances required by Medicare and/or LA Regulation 33 and ends no later than 63 days as described pursuant to Medicare regulations and/or LA Regulation 33, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare Supplement policy.

B. INDIVIDUAL CASE MANAGEMENT

1. Case Management Services

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

2. The role of Case Management is to assist You by assessing, helping You set goals for overcoming barriers to good health and with coordination of services, and advocating for Your health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.

3. This policy supplements Medicare to the extent that it is required to supplement Medicare, regardless of Individual Case Management.

C. THIS CONTRACT

1. This Contract, including the application for coverage expressing the entire money and other consideration therefor, the Schedule of Benefits if any and any attached amendments or endorsements, constitutes the entire Contract between the parties.

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

3. The Company reserves the right to enter into any contractual agreement with subcontractors, health care providers, or other third parties relative to this Contract. Any of the functions to be performed by the Company under this Contract may be performed by the Company or any of its subsidiaries, affiliates, subcontractors, or designees.

4. Our liability is limited to the benefits specified in this Contract. Benefits for covered services specified in this Contract will be provided only for services and supplies rendered on and after Your Effective Date.

D. CONTRACT CHANGES

Subject to applicable laws, no agent may change this Contract other than by amendment or endorsement issued by Us to form a part of this Contract. This amendment or endorsement must be signed by one of Our executive officers. No representation of any agent of the plan at any time shall change the terms of this Contract.

E. RELEASE OF INFORMATION

We may request that You or the provider furnish certain information relating to Your claim for benefits. We will hold such information, records, or copies of records as confidential except where in Our discretion the same should be disclosed.

F. PHYSICAL EXAMINATION

We reserve the right to require a physical examination of any Policyholder when and as often as We deem necessary during the pending of any claim.

G. NON-RESPONSIBILITY FOR ACTS OF PROVIDERS

A health care provider which provides services to You does so independently of Us. We will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, allied provider, nurse, technician or other person participating in or having to do with Your care or treatment.

H. CANCELLATION OF CONTRACT OR CHANGE OF PREMIUMS

1. We reserve the right to cancel Your Contract for non-payment of premium to Our home office within thirty (30) days after the due date. If We cancel or do not renew this Contract for any reason other than non-payment of premiums, We shall mail to You a written notice of such action by certified mail or certificate of mailing at least sixty (60) days in advance. The notice shall include the reason for the cancellation or non-renewal.

2. If You fail to timely pay the required premium, Our subsequent acceptance of the premium or acceptance by any agent authorized by Us to accept premiums, shall reinstate this Contract.

3. Premiums are based on the benefits provided by the Contract, Your attained age, and the geographic region in which You live. Premiums for Your Contract are established prior to the effective date of Your Contract and from time-to-time thereafter. Each premium that We establish for Your Contract will remain in effect for a period of not less than twelve (12) months, except in the following situations.

    a. We reserve the right to make changes in the premiums under your Contract in order to correct any errors concerning the information on which premiums are based.

    b. We reserve the right to change premiums if You request a change in the benefits provided by the Contract and We agree to make that change. The new premiums will become effective on the effective date of the Contract change, regardless of how long the premiums had been in effect prior to change.

    c. We will give forty-five (45) days written notice to You at Your last address shown in Our records regarding any change in rates; such increase in premiums will become effective on the date specified in the notice and continued payment of premiums will constitute acceptance of the change.

    d. Increases in premiums become effective on the date of the change regardless of whether or not You have paid premiums in advance. We will notify You of the amount due. Failure to pay that amount timely as indicated in the notice will result in cancellation of this Contract.

I. TERMINATION OF A POLICYHOLDER'S COVERAGE

1. Except as provided in this subsection, We shall renew or continue coverage under this policy on a month-to-month basis, at Your option.

2. The issuance of this policy is conditioned on the representations and statements contained on the application, a copy of which is attached to and made a part of this policy. Representations made on the application are material to the issuance of this policy. Your coverage may be terminated for fraud at any time. Within three (3)

years from Your Original Effective Date, this policy may be terminated if We become aware of any misrepresentations or omissions of a material fact and if knowledge of this material fact would have led Us to deny coverage. If Your Contract is terminated, We shall refund any premiums You paid from the Original Effective Date, if benefits have not been provided. If benefits have been provided, the premiums paid will be reduced by the benefits paid and the balance, if any, will be refunded.

3. In addition to above, We may non-renew, discontinue, or terminate health insurance coverage under this policy as provided below:

   a. You fail to pay premiums or contributions in accordance with the terms of this policy or We have not received timely premium payments.

   b. We cease to offer coverage in the market or discontinue offering a particular type of coverage, unless otherwise required by Medicare.

4. In the event that We terminate this policy for nonpayment of the appropriate payment when due or for Your failure to perform any obligation required by this policy, such cancellation or termination alone will operate to terminate all of Your rights to benefits under the terms of this policy as of the effective date of such cancellation or termination.

5. However, in the event of termination under paragraph 3 above, if You are an inpatient in a Hospital on the date of termination, Hospital benefits for that patient will terminate at the end of the Hospital stay, the end of the Benefit Period, or upon reaching any benefit limitations set forth in this policy, whichever occurs first.

6. Except as otherwise provided in this policy, no benefits are available to You for covered services rendered after the date of termination of Your coverage.

7. You have the right to cancel this policy at any time. Cancellation must be sent in writing to Us at Our home office, attention "Individual Membership and Billing Department." Cancellation will be effective at midnight on the last day of the billing cycle in which the notice was received, or a later billing cycle, if specifically requested. Billing cycles begin on the 1st or the 16th of the month.

J. SUBROGATION

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

2. You will reimburse us all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier provides benefits directly to a Policyholder who is its insured, to the extent of the benefits provided or paid under this Contract. Our right to reimbursement shall be subordinate to Your right to be "made whole." We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.

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

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

K. PROXY VOTES

Election of Our Board of Directors and certain significant corporate transactions are determined by a majority vote of Our Policyholders, unless a different vote is required by law or Our Articles of Incorporation or Bylaws. A Policyholder designates, by means of the application for coverage, the members of Our Board of Directors as his or her proxy to vote on these important matters. Payment of each premium extends the proxy's effectiveness unless revoked by the Policyholder. This proxy may be revoked by the Policyholder by giving written notice of the revocation. This revocation may be in any form of writing either revoking the proxy or designating a different proxy and must be sent to Us at P.O. Box 98029, Baton Rouge, Louisiana 70898-9029. In lieu of giving his or her proxy in the application for coverage, the Policyholder may designate any other Policyholder as his or her proxy by any form of writing which includes the Policyholder's name and Policy number, sent to Us as indicated above. Notice of meetings to the proxy constitutes notice to the Policyholders giving their proxies. Further, notice is hereby given that Our annual meeting is held on the third Tuesday in February or on the next business day following, if a legal holiday.

However, additional notice of meetings will be sent to any Policyholder or his or her proxy upon his or her written request for such notice directed to Our secretary.

L. OTHER INSURANCE WITH US

You may have only one Medicare Supplement policy. If through error, We issue more than one such policy to You, only one policy chosen by You will stay in effect. We will return the money You paid for the other policies, less any claims payment already made under the other policies. Also, You may not have this policy in addition to another individual (non-group) Blue Cross and Blue Shield of Louisiana Contract or HMO Louisiana Contract providing Hospital, medical and/or comprehensive coverage.

M. GRACE PERIOD

The Company offers a thirty (30) day grace period (delinquent period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the policy. If We do not receive the premium during the grace period, We will mail a delinquency/lapse notice to the Insured's address of record. We may automatically terminate the policy without further notice to the Insured if we do not receive Your premium at Our home office within thirty (30) days of the due date (during the grace period). If We terminate this Contract for nonpayment of premium, termination will be effective midnight of the last day for which the premium have been paid. The Company will not be liable for any benefits for services rendered following the last date through which premiums have been paid.

N. FILING OF CLAIMS

In order for Us to process Your claim, We must receive an Explanation of Medicare Benefits (EOMB) Form. This form should be filed with Us within ninety (90) days after completion of Medicare processing, with Your Blue Cross and Blue Shield of Louisiana Contract number noted on it. If it was not reasonably possible for this form to be filed in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible, but no longer than one year from the completion of Medicare processing. Claims are usually filed electronically with Medicare by the health care provider, and then Medicare usually files the claim with Us.

No claim for loss incurred after the Original Effective Date of coverage shall be reduced or denied on the ground that a disease or physical condition had existed before the Original Effective Date of coverage.

If Medicare Part A benefits have exhausted and/or You are not participating in Medicare Part B, and if You have a claim which would otherwise have been covered under Medicare Parts A and/or B, You must file Your claim (either written or electronic) in a form acceptable to Us within ninety (90) days from the date services are rendered. If the form cannot be sent within ninety (90) days, it must be sent as soon as reasonably possible but no longer than fifteen (15) months from the date services are rendered. Benefits will be denied for claims filed any later than after fifteen (15) months from the date services are rendered.

We will, upon receipt of a notice of claim, furnish to You such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, You will be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time fixed in this Contract for filing proofs of loss, any affirmative written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

O. PAYMENT OF CLAIMS

1. Your rights and benefits under this Contract are personal to You and may not be assigned in whole or in part by You. We will not recognize any assignments or attempted assignments of benefits, unless otherwise required by Medicare. However, We will recognize assignments of benefits to Hospitals if this Contract is subject to La. R.S. 40:2010. If this Contract is not subject to La. R.S. 40:2010, We will not recognize any assignments or attempted assignments of benefits to Hospitals, unless otherwise required by Medicare. Nothing contained in the written description of health coverage shall be construed to make the health plan or Us liable to any third party to whom You may be liable for medical care, treatment, or services.

2. We reserve the right to pay providers and Hospitals in Our participating provider networks directly instead of paying You.

3. Any unassigned benefits unpaid at Your death may be paid to Your estate.

4. This policy pays the provider and follows assignment to the extent it is required to do so by Medicare.

5. Indemnities payable under this policy for any loss other than loss of time on account of disability will be paid upon receipt of written proof of such loss as required by law.

P. LEGAL ACTION

No legal action may be brought to recover on this policy within sixty (60) days after Our receipt of the Explanation of Medicare Benefits Form upon completion of Medicare Processing. No such action may be brought after fifteen (15) months from the date of service or after one (1) year from completion of Medicare processing, whichever is longer.

During the three hundred sixty five (365) days benefit for Part A and/or if You are not participating in Medicare Part B, no lawsuit may be filed any earlier than the first sixty (60) days after the notice of claim has been given or any later that fifteen (15) months from the date of service.

Q. APPLICABLE LAW

This Contract will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law.

R. CONTINUATION OF COVERAGE

This policy provides for continuation of coverage in the event the Secretary of Health and Human Services determines that the policy should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment. If this policy is discontinued, You may purchase, without requiring evidence of insurability, any Medicare Supplement Contract offered by Blue Cross and Blue Shield of Louisiana which

has comparable or lesser benefits and which does not contain a restricted network provision. A policy is considered to have comparable or lesser benefits unless it has one or more significant benefits not included in the policy being replaced.

S. CONFORMITY WITH STATE STATUTES

Any provision of this policy which, on its Original Effective Date, is in conflict with the laws of the state of Louisiana on that date is amended to conform to the minimum requirements of such laws, to the extent applicable to Medicare Supplement Policies.

T. INDEPENDENT LICENSEE

Member applicant hereby expressly acknowledges its understanding that this policy constitutes a Contract solely between member applicant and Blue Cross and Blue Shield of Louisiana (the "Company"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the Association) permitting the Company to use the Blue Cross and Blue Shield Service Marks in Louisiana, and that the Company is not contracting as the agent of the Association. Member applicant further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than the Company and that no person, entity or organization other than the Company shall be held accountable or liable to the member applicant for any of the Company's obligations to the member applicant created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of the Company other than those obligations created under other provisions of this agreement.

U. RIGHT OF RECOVERY

Whenever any benefits payment has been made by Us in an amount that exceeds the maximum benefits available under this Contract or exceeds the Allowable Charge, or whenever payment has been made in error by Us, We will have the right to recover such payment from You or, if applicable, the provider. As an alternative, We reserve the right to deduct from any pending claim for payment under this Contract any amounts We are owed by You or the provider.

ARTICLE VIII. COMPLAINTS, GRIEVANCE AND APPEALS PROCEDURES

We want to know when You are unhappy about the care and/or services You receive from Us or if you have a Blue Choice 65 Select Medicare Supplement policy, from one of Our Select network providers. If You want to register a complaint or file a formal written grievance about Us or a provider, please refer to the procedures below.

You may be unhappy about decisions that We make regarding covered services. We consider Your request to change Our coverage decision as an appeal. We define an appeal as a request from an Insured or authorized representative to change a previous decision made by the Company about covered services.

Examples of issues that qualify as appeals include denied authorizations, claims based on adverse determinations of Medical Necessity, or benefit determinations.

Your appeal rights are outlined below, after the complaint and grievance procedure section. 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.

We have an expedited appeals process for situations where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. That process is outlined following the Standard Appeal Procedure section.

A. Complaint and grievance procedure

A complaint is an oral expression of dissatisfaction with Us or with provider services. A quality of care concern addresses the appropriateness of care given to You. A quality of service concern addresses Our services, access, availability or attitude and if you have a Blue Choice 65 Select Medicare Supplement policy, those of Our Select network providers.

1. To register a complaint

   Call Our Customer Service Department at 1-800-258-3365. We will attempt to resolve Your complaint at the time of Your call.

2. To file a formal grievance

   A grievance is a written expression of dissatisfaction with Us or with provider services. If You do not feel Your complaint was adequately resolved or You wish to file a formal grievance, You must submit this in writing. Our Customer Service Department will assist You if necessary. Send Your written grievance to:

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

   A response will be mailed to You within thirty (30) business days after We receive Your written grievance. If You are not happy with Our handling of Your grievance, You have the right to elevate Your grievance to the second and final level. We must receive Your request for a second level grievance no later than sixty (60) calendar days from the date We notified You of the answer to the first level grievance. Grievances received after this date will not be considered. Each level of the grievance procedure is reviewed by a separate panel.

B. Informal Reconsideration

An informal reconsideration is Your provider's telephone request to speak to Our Medical Director or a peer reviewer on Your behalf 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 or concurrent review determinations that are requested within ten (10) days of the denial. We will conduct an informal reconsideration within one (1) working day of the receipt of the request.

C. Standard Appeal Procedure

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

We recognize that disputes may arise between Us and Our Insureds regarding covered services. An appeal is a written request from You to change a prior decision that We have made. Examples of issues that qualify as appeals include denied authorizations, denied claims or determinations of Medical Necessity. We will distinguish Your appeal as either an administrative appeal or a Medical Necessity appeal.

We intend to make the appeals process one of timely response, timely documentation and timely resolution of such disputes. The procedure has two (2) internal levels, including review by a committee at the second level. You are encouraged to provide Us with all available information to help Us completely evaluate Your appeal. Medical Necessity appeals also offer You the opportunity to appear in person or telephonically at a committee meeting as well as an opportunity for review by an independent external review organization.

You have the right to appoint an authorized representative to represent You in Your appeal. An authorized representative is a person to whom You have given written consent to represent You in an internal or external review of a denial. The authorized representative may be Your treating provider, if You appoint the provider in writing and the provider agrees and waives in writing, any right to payment from You other than any applicable Coinsurance amount. Providers will be notified of the appeal results only if the provider filed the appeal.

1. First Level of Internal Appeal

   If You are not satisfied with Our denial of services, You, Your authorized representative, or a provider acting on Your behalf, must submit his initial written request to appeal within one-hundred eighty (180) days following Insured's receipt of an initial adverse benefit determination. Appeals should be submitted in writing to:

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

If You have questions or need assistance putting the Appeal in writing, You may call Our Customer Service Department at 1-800-258-3365. Requests submitted to Us after one-hundred eighty (180) days of the denial will not be considered.

We will investigate Your concerns. All appeals of Medical Necessity denials will be reviewed by a Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. If Our initial denial is overturned on Your administrative or Medical Necessity appeal, We will process Your claim and will notify You and all appropriate providers, in writing, of the first level appeal decision. If Your claim is denied on appeal, We will notify You and all appropriate providers when applicable, in writing, of Our decision. The decision will be mailed within thirty (30) working days of Your request, unless You, Your authorized representative and We mutually agree that an extension of the time is warranted. At that time, We will inform You of Your right to begin the second level appeal process.

2. Second Level of Internal Appeal

Within sixty (60) calendar days of the date of Our first-level appeal decision, an Insured who is not satisfied with the decision may initiate, with assistance from the Customer Service Unit, if necessary, the second level of the appeal process, by writing to:

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

If You have questions or need assistance putting the appeal in writing, You may call the Customer Service Department at 1-800-258-3365. Requests submitted to Us after sixty (60) days of the denial will not be considered.

A Member Appeals Committee not involved in any previous denial will review all second-level appeals. For Medical Necessity appeals only, We will advise You or Your authorized representative of the date and time of the review meeting, which You or Your authorized representative may attend. The review meeting is normally held within forty-five (45) working days of Our receipt of Your request for a second-level appeal.

You or Your authorized representative have the right to attend the review meeting for Medical Necessity appeals, present Your position, and ask questions of the committee members present, subject to the rules of procedure established by the committee. If You are unable to appear before the committee, but wish to participate, We will make arrangements for You to participate by means of available technology. For Medical Necessity appeals, a Physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review must agree with any adverse decision made by the committee. The committee will mail its decision regarding either Your administrative or Medical

Necessity appeal to You within five (5) working days after the meeting. The committee's decision is final and binding as to any administrative appeal. Medical Necessity appeals only can be elevated to the third and final review by an independent external review organization.

3. Independent External Review

If You still disagree with the Medical Necessity denial, and have the concurrence of Your treating Physician, You may request an independent external appeal conducted by a non-affiliated Independent Review Organization (IRO). Within sixty (60) days of receipt of the second level Appeal decision, You should send Your written request for an external review to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-523-6435

Requests submitted to Us after sixty (60) days of receipt of the denial will not be considered.

We will provide the IRO all pertinent information necessary to conduct the appeal. The IRO decision will be considered a final and binding decision on both the Insured and the Company. The IRO review will be completed within seventy-two (72) hours after the appeal is commenced if the request is of an urgent or emergent nature. Otherwise, the review will be completed within thirty (30) days from the receipt of the information from Us, unless a longer period is agreed to by the parties. The IRO will notify You or Your authorized representative and Your health care provider of its decision.

D. Expedited Appeals

1. Expedited Internal Appeal

We provide an Expedited Internal Appeal process for review of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize Your life, health or ability to regain maximum function. In these cases, We will make a decision no later than seventy-two (72) hours after the review commences.

An expedited appeal is a request concerning an admission, availability of care, continued stay, or health care service for a covered person who is requesting Emergency services or has received Emergency services, but has not been discharged from a facility. 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 covered person or an authorized representative, with the consent of the covered person's treating health care provider, or the provider acting on behalf of the covered person.

Requests for an Expedited Internal Appeal may be oral or written and should be made to:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal Appeals and Grievance Unit P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-599-2583 or 1-225-291-5370

We must receive proof that Your provider supports this request for an expedited internal appeal.

In any case where the expedited internal appeal process does not resolve a difference of opinion between Us and the covered person or the provider acting on behalf of the covered person, the appeal may be elevated to a second level standard internal appeal or an expedited external review.

2. Expedited External Review

An expedited external review is a request for immediate review, by an independent review organization (IRO), of an adverse initial determination not to authorize continued services for Insureds currently in the Emergency room, under observation in a facility or receiving Inpatient care. Your health care provider must request the expedited external review. Expedited external reviews are not provided for review of services previously rendered. An expedited external review of an adverse decision is available if pursuing the standard appeal procedure could seriously jeopardize Your life, health or ability to regain maximum function.

Within sixty (60) days of the denial, the provider should contact Our Appeals Coordinator at 1-800-376-7741 or 1-225-293-0625 or send a written request to:

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

We will forward all pertinent information to the IRO so the review is completed no later than seventy- two (72) hours after the review commences.

E. Binding Nature of External Review of a Medical Necessity Decision

The process of seeking a Medical Necessity appeal is set forth above. All external review decisions are binding on Us and the covered person for purposes of determining coverage under a health benefit plan that requires a determination of Medical Necessity for a medical service to be covered. This appeals process shall constitute Your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary.

LLHIGA NOTICE

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

A. Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association, or LLHIGA. The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage. Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer. The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

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

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

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

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

D. Exclusion from Coverage

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

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

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

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

2. LLHIGA also does not provide coverage for:

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

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

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

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

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

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

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

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

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

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

E. Limits on Amounts of Coverage

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

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

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

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

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

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

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

Nondiscrimination Notice

Discrimination is Against the Law

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

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

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

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

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

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

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

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

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

Or

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

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

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratuitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 1-800-711-5519 (TTY 711).

我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك.
إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒤에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos grátis. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ພວກເຮົາມີບໍລິການແປພາສາໃຫ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫູບໍ່ດີ, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔
سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید.
مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน
สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)