# Medicare Supplemental Policy

## Standardized Benefit Plan G Select Plus

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

Blue Cross and Blue Shield of Louisiana

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

*www.bcbsla.com*

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

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

## TABLE OF CONTENTS

**ARTICLE I. DEFINITIONS ..... 5**

**ARTICLE II. BENEFITS ..... 8**

**ARTICLE III. BASIC CORE BENEFIT COVERAGE ..... 9**

**ARTICLE IV. ADDITIONAL COVERAGE ..... 10**

**ARTICLE V. NETWORK HOSPITAL RESTRICTION ..... 11**

**ARTICLE VI. EXCLUSIONS ..... 12**

**ARTICLE VII. DENTAL CARE BENEFITS ..... 13**

**ARTICLE VIII. GENERAL PROVISIONS ..... 18**

**ARTICLE XI. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES ..... 26**

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.

## UNITED CONCORDIA DENTAL

United Concordia Companies, Inc. doing business as United Concordia Dental (hereinafter "United Concordia Dental" or "UCD") is Blue Cross and Blue Shield of Louisiana's network and claims administrator for the dental Benefits provided in this Contract, and is in charge of managing the dental network, handling and paying claims, and providing customer services to the Insureds eligible to receive these benefits.

The United Concordia Dental Advantage Plus Network consists of a select group of Providers who have contracted with United Concordia Dental to render services to Insureds for discounted fees. **In order to receive the full dental benefits, the Insured should verify that a Provider is a United Concordia Dental Network Participating Provider before any service is rendered.** To locate a Participating Provider and verify their continued participation in the United Concordia Dental Advantage Plus Network, or to ask any questions related to Benefits or claims, please visit the website at **www.bcbsla.com** or contact a customer service representative at (866) 445-5338.

## 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 ninety (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 reasonably 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 Louisiana Department of Insurance 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:

1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient Hospital Deductible amount per Benefit Period.

2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Coinsurance amount from the twenty-first (21st) day through the one hundredth (100th) day in a Medicare Benefit Period for post Hospital Skilled Nursing Facility care eligible under Medicare Part A.

3. 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.

4. 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.) 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, unless specifically covered under this policy;

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. DENTAL CARE BENEFITS

In order to receive full benefits, dental services must be performed by a provider in the United Concordia Dental Advantage Plus Network.

Annual allowance of $1,200 per year for all dental services combined, whether preventive services or basic services. We will pay Benefits up to the Allowable Charge for Covered Services not to exceed the foregoing annual allowance.

For all covered dental services, a year means a calendar year.

### A. Definitions *(Applicable only to the Dental Care Benefits Article of this Contract)*

1. Allowable Charge – The lesser of the billed charge or the amount established by UCD as the greatest amount this policy will allow for a specific service covered under the terms of this policy.

2. Amalgam – A durable metal alloy comprised of silver, copper, tin, and mercury used in dental restorations.

3. Benefits – Coverage for dental services, treatments or procedures provided under this policy. Benefits are based on the Allowable Charge for Covered Services.

4. Claim- A Claim is written or electronic proof, in a form acceptable to UCD, of charges for Covered Services that have been incurred by You during the time period You were insured under this policy. The provisions in effect when the service or treatment is received will govern the processing of any Claim expense actually incurred as a result of the service or treatment given.

5. Covered Service – A service or supply specified in this policy for which Benefits are available when rendered by a Provider.

6. Crown – A tooth-shaped cap that is placed over a tooth to cover it and restore its shape and size, strength, and improve its appearance. When a Crown is cemented into place, it fully encases the entire visible portion of a tooth that lies at and above the gum line.

7. Dental Care and Treatment – All procedures, treatment, and surgery considered to be within the scope of the practice of dentistry, which is defined as that practice in which a person:

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

b. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a Filling, Crown, denture, or other appliance; or

c. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair Prosthetic Dentures, bridges, or other substitute for natural teeth to the user or prospective user.

8. Dentist – A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioners under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

9. Endodontic (Pulpal) Therapy – A dental procedure that is performed when the decay in a child's tooth reaches into the pulp (nerve) tissue. The infected part of the nerve tissue within the crown portion of the tooth is removed to prevent further inflammation and spread of disease (caries). During this treatment, the diseased pulp tissue is partially or completely removed from both the Crown and the roots of the tooth. The canals are cleansed, disinfected, and filled with a special material.

10. Filling – A dental restorative material used to restore the function, integrity and form of missing tooth structure, which may result from caries or external trauma.

11. Prosthetic Dentures – Prosthetic devices constructed to replace missing teeth, and which are supported by surrounding soft and hard tissues of the oral cavity. Conventional dentures are removable; however, there are many different denture designs, some which rely on bonding or clasping onto teeth or Dental Implants.

12. Provider – A Physician or Dentist, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by UCD. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members for Benefits in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

    a. Participating Provider – A Provider that has a Provider Agreement with the United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

    b. Non-Participating Provider – A Provider that does not have a Provider Agreement with the United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

13. Provider Agreement – An agreement for payment contracted by UCD with Participating Providers. These agreements establish the actual payments which will be made to the Participating Provider.

14. Resin-Based Composite – Material composed of plastic with small glass or ceramic particles, which resemble the appearance of natural teeth.

15. UCD – United Concordia Companies, Inc. d/b/a United Concordia Dental, the network and claims administrator for the dental Benefits in this plan.

**B. Preventive Services**

1. Oral Exams

   Limited to two (2) exam(s) every year.

2. Routine Cleaning

   Limited to two (2) cleaning(s) every year.

3. Horizontal Bitewing X-rays

   Limited to one (1) set every year.

**C. Basic Services**

1. Adjustments of Prosthetics

   Up to one (1) per arch per two (2) years.

2. Repairs of Prosthetics

   Up to one (1) arch per three (3) years.

3. Amalgam Replacement Restorations (Metal Fillings)

   Limited to one (1) visit, per tooth, every thirty-six (36) months.

4. Resin-Based Composite Replacement Restorations (Anterior)

   Limited to one (1) visit per tooth, every thirty-six (36) months.

5. Endodontic Therapy and Services

   Limited to one (1) visit per tooth per lifetime.

6. Palliative Treatment (ER)

   Limited to one (1) visit per year.

7. Extractions

   No limit to simple surgical extractions.

**D. Exclusions** *(Applicable only to the Dental Care Benefits Article of this Contract)*

Only American Dental Association procedure codes are covered under this Article. No coverage will be provided under this Article except as specifically outlined in this policy.

**E. Filing of Dental Claims** *(Applicable only to the Dental Care Benefits Article of this Contract)*

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

UCD and Participating Providers have entered into agreements that eliminate the need for You to personally file a Claim for Benefits. Participating Providers will file Claims for You either by mail or electronically. In certain situations, the Provider may request You to file the Claim. If Your Provider does request You to file directly with the Company, the following information will help You in correctly completing the Claim form.

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.

If You have any questions about any of the information in this section, You may call Your insurance agent or Our Customer Service Department at the number shown on the ID Card.

Your Blue Cross and Blue Shield of Louisiana ID Card shows the way Your name appears on the Company records. The ID Card also lists Your Contract number (ID #). This number is the identification to Your membership records and should be provided to Us each time a Claim is filed.

To assist in promptly handling Your Claims, please be sure that:

1. an appropriate Claim form is used;

2. the Contract number (ID #) shown on the form is identical to the number on the ID Card;

3. Your date of birth is listed;

4. all charges are itemized in a statement from the Provider;

5. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form;

6. the date of service (admission to a Hospital or other Provider) or date of treatment is correct;

7. the Provider includes a diagnosis code and a procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form); and

8. the Claim is completed and signed by You.

9. If You need to submit documentation to Us, please send it to:

United Concordia Dental
Attention: Claims Department
P. O. Box 69441
Harrisburg, PA 17106-9441

**F. Appeals** *(Applicable only to the Dental Care Benefits Article of this Contract)*

You may be dissatisfied about decisions made regarding Covered Services. UCD considers an Appeal as Your written request to change a decision regarding a Covered Service. Your Appeal rights are outlined in the Complaint, Grievance and Appeals Procedures Article below.

You may call UCD if You have questions or need assistance putting Your Appeal in writing.

All Dental Appeals should be submitted to:

United Concordia Dental
Appeals Division
P. O. Box 69420
Harrisburg, PA 17106-9420

## ARTICLE VIII. GENERAL PROVISIONS

### A. BENEFIT AND PREMIUM CHANGE

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.

### B. 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.

### C. 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.

## D. 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.

## E. 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.

## F. 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.

## G. 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.

## H. 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.

## I. 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.

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

4. In the event that We terminate this policy for nonpayment of the appropriate payment when due, 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.

## K. 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 be required 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.

## L. 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:

Blue Cross and Blue Shield of Louisiana
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 in the month of February with notice of the date of that meeting being given as required by law and the articles and bylaws of the Louisiana Health and Service Indemnity Company. 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.

## M. 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.

## N. 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 has been paid. The Company will not be liable for any benefits for services rendered following the last date through which premiums have been paid.

## O. 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.

## P. 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.

## Q. 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 than fifteen (15) months from the date of service.

## R. 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.

## S. 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.

## T. CONVERSION PRIVILEGE

This policy provides that You may request to purchase 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. We shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select Contract has been in force for six (6) months.

## U. 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.

## V. 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.

## W. 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 XI. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when You are dissatisfied about the care or services You receive from Us or one of Our providers. If You want to register a complaint or file a formal written grievance about Us or a provider, please refer to the procedures below.

You may be dissatisfied about decisions that We make regarding covered services. We consider a written Appeal as the Member's request to change a denial of a claim.

### A. Complaint and Grievance Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Our providers. A quality of care concern addresses the appropriateness of care given to You.

1. To register a complaint

   A complaint is an oral expression of dissatisfaction with Us or with provider services. You may call Our customer service department at 1-800-258-3365 to register a complaint.

   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, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, You may call Our customer service department. Send 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 of receipt of Your written grievance.

### B. Appeal Procedures

The Appeals procedure has two (2) internal, administrative levels, including review by a committee at the second level.

If You have questions or need assistance, You may call Our customer service department.

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

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 review of a denial.

The authorized representative may be Your treating provider, if You appoint the provider in writing.

You are encouraged to provide Us with all available information to help Us completely evaluate the appeal such as written comments, documents, records, and other information relating to the denial.

We will provide to You, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the denial.

Administrative appeals involve contractual issues and are typically submitted by You, Your authorized representative, or a provider authorized to act on Your behalf.

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

1. First Level Appeals

   If You are not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of Our initial denial. Requests submitted to Us after one hundred eighty (180) days of Our initial denial will not be considered.

   Persons not involved in previous decisions regarding the initial denial will review the Appeal. If the Appeal is overturned, We will reprocess Your Claim. If the Appeal is upheld, We will inform You of the right to begin the second level Appeal process.

   The Appeal decision will be mailed to You, Your authorized representative, or a provider authorized to act on Your behalf, within thirty (30) days of receipt of Your request; unless it is mutually agreed that an extension of time is warranted.

2. Second Level Appeals

   After review of Our second level appeal decision, if You are still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of Our first level Appeal

decision. Requests submitted to Us after sixty (60) days of Our first level Appeal decision will not be considered.

An Appeals Committee of persons not involved in previous decisions regarding the initial denial will review the second level Appeals. The Committee's decision is final and binding.

The Committee's decision will be mailed to You, Your authorized representative, or a provider authorized to act on Your behalf, within five (5) days of the Committee meeting.