PLAN F

Cancer and Serious Disease

LIMITED BENEFIT CONTRACT

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

23XX9978 R01/25

THIS IS A LIMITED BENEFIT POLICY. READ CAREFULLY.

Your Cancer and Serious Disease Plan: Plan F

Your Cancer and Serious Disease Plan **has limited Benefits. Read it carefully to make sure that You understand what this Plan offers You.**

This Plan has a 60-day Waiting Period. That means We will not pay Benefits for any services, supplies, or treatment until 60 days after the Effective Date of the Contract.

This Contract is not a Medicare supplement policy. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the Company.

THIS CONTRACT IS SUBJECT TO CANCELLATION OR NON-RENEWAL AT THE OPTION OF THE INSURER.

From time to time, We may change this Plan. If We do change it, We will usually do so on the same date every year — the anniversary of this Plan. But We will tell You about any changes before We make them.

Blue Cross and Blue Shield of Louisiana is licensed to sell insurance only in the state of Louisiana. If You move outside of Louisiana and You plan to relocate or live outside the state, Your coverage will end.

If You decide that You do not want this Contract; You may return it within 10 days after You receive it and We will refund Your fees.

Bryan R. Camerlinck
President and Chief Executive Officer

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

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, health maintenance organization, 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, health maintenance organization, 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, 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 A coverage", "Medicare Part B coverage", "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.

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Article 1. What Are the Basics About this Plan?

We at Blue Cross and Blue Shield of Louisiana issue this Contract to *You*, the Subscriber. We also call this Contract a *Plan*. In this Plan, We describe Your Benefits and Your rights and responsibilities. In this document, We explain what the Plan covers and what it does not cover. Also, *Article 3: Schedule of Eligibility* explains who may be covered under the Plan. We agree to provide the Benefits explained in the Plan for You and the Dependents You enroll.

Because many sections of this Plan relate to other sections, You must read the entire Plan to have all the information You need to understand it. To help You better understand Your Plan, We give You a full list of the terms in *What Terms Do We Use in this Plan?*

While this Plan explains terms and provisions, Your *Schedule of Benefits* tells You specific financial information. It tells You what type of plan You bought. To fully understand Your insurance Plan, You must carefully read both Your *Schedule of Benefits* and this Plan.

As of the Contract Date, this Plan replaces any others We issued to You. If We use a word in the masculine gender in this document, it applies also in the feminine gender, unless We state otherwise.

How Your Plan Works

This Plan has limited Benefits. It pays Benefits only if You have certain diseases. Once You are diagnosed with one of the following diseases, Your Plan pays limited Benefits for Your treatment. Your Plan covers:

- Cancer (any type or any kind),
- Poliomyelitis,
- Leukemia,
- Diphtheria,
- Tetanus,
- Spinal Meningitis (*Meningococci*),
- Scarlet Fever,
- Small Pox,
- Polio,
- Tularemia,
- Encephalitis (*Sleeping Sickness*),
- Rabies, and
- Sickle Cell Anemia.

You must read and understand Your Plan Yourself. Your doctor does not have a copy of it, and does not know and cannot tell You what Benefits You have.

This Plan includes Benefits in these categories	
Hospital Benefits	
Medical and Surgical Benefits	
Prescription Drug Benefits	
Benefits for Other Covered Services, Supplies, or Equipment	

Your *Schedule of Benefits* tells You the percentage of Allowable Charges We pay for Covered Services and the percentage You pay. (We call this *Coinsurance*.) Your *Schedule of Benefits* also tells You the maximum amount of Benefits We will pay during Your lifetime.

To make the cost of care more affordable, We have contracts with a wide range of Providers.

- **If You go to a Provider who has a contract with Us,** We will pay Your Provider.
- **If You file Your Claim Yourself,** We will pay You directly.

If You have questions about Your coverage or about any limits to the coverage,

— Call Us at 1-800-599-2583 or 1-225-291-5370,

— Write to Us at **help@bcbsla.com**, or

— Go to **www.bcbsla.com** for details about how to contact Us by phone, fax, email, postal mail, and walk-in customer service. At the upper right of every page online, You will see *Contact Us*.

Online, You will also find a wide range of health management and wellness tools and resources to manage Your personal accounts, create health records, and access a host of wellness interactive tools. We offer a comprehensive wellness program with a personal health assessment and customized health report to assess any risks based on Your history and habits. You will also find exclusive discounts on some health services such as fitness club memberships, diet and weigh-control programs, vision and hearing care, and more.

Assignment of Benefits: Your rights and Benefits under this Plan are Yours alone. You may not give them to anyone else.

If You are treated for a Covered Disease, You may ask Us to pay Your Benefits directly to the Hospital if both this Plan and the Provider are subject to La. R.S. 40:2010. We call paying Your Benefits to someone else *assignment of Benefits*. If both this Plan and the Provider are not subject to La. R.S. 40:2010, We will not pay Your Benefits to the Hospital.

Nothing in the written description of health coverage makes the Plan or Us bound by law to pay any third party to whom You may owe the cost of medical care, treatment, or services.

Article 2. What Terms Do We Use in this Plan?

The inclusion of any definition in this Article does not denote that any particular benefit, condition, diagnosis, procedure, service, or treatment is covered under this Contract. Please review the Contract in its entirety to determine Your Coverage.

Admission – The period for Inpatient care from entry (*Admission*) into a Hospital or Skilled Nursing Facility or Unit until discharge. In counting days of care, We count the date of entry and the date of discharge as 1 day.

Allied Health Facility – An institution — other than a Hospital — that the appropriate state agency licenses, where required, or that We approve to give Covered Services.

Allied Health Professional – A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, or approved by Us to give Covered Services. For this Plan, *Allied Health Professional* includes dentists, psychologists, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, Physician's assistants, registered nurse first assistants, advanced practice registered nurses, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as state law mandates for specified services, if We approve them to give Covered Services.

Allied Provider – Any Allied Health Facility or Allied Health Professional.

Allowable Charge – Either the billed charge or the amount We establish or negotiate as the most We will pay for services covered under this Plan, whichever is less.

Ambulance Service – Transportation by a specially designed and specially equipped vehicle that is used only to transport sick and injured people.

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of Physicians. This type of center has permanent facilities that are equipped and operated mainly to perform surgical procedures. A center has continuous Physician and registered professional nursing services available whenever patients are in the facility, does not provide services or other accommodations for patients to stay overnight, and offers the following services whenever patients are in the center:

- Anesthesia services as needed for medical operations and procedures performed;
- Provisions for patients' physical and emotional well-being;
- Provision for Emergency services;
- Organized administrative structure; and
- Administrative, statistical, and medical records.

Appeal – A written request from a Member or a Member's authorized representative to change a decision We made about Benefits.

Bed, Board and General Nursing Service – Room accommodations, meals, and all general services and activities that Hospital employees provide to care for patients. This service includes all nursing care and nursing instructional services provided as a part of the Hospital's bed-and-board charge.

Benefits – Amount We pay for healthcare services, treatment, procedures, equipment, drugs, devices, items, or supplies under this Plan. We base the Benefits We pay on the Allowable Charge for Covered Services; then We apply Our Coinsurance percentage, up to the Lifetime Maximum Payment amount.

Benefit Period – A calendar year — January 1 through December 31.

Care Coordination – Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator Fee – A fixed amount paid by Blue Cross and Blue Shield of Louisiana to Providers periodically for Care Coordination under a Value-Based Program.

Cellular Immunotherapy – A treatment involving the administration of a patient's own (autologous) or donor (allogeneic) anti-tumor lymphocytes following a lymphodepleting preparative regimen.

Chiropractic Services – Diagnosing conditions associated with the functional integrity of the spine and treating those conditions by adjusting, manipulating, and using physical and other properties of heat, light, water, electricity, sound, massage, therapeutic exercise, mobilization, mechanical devices, and other rehabilitative measures to correct interference with normal nerve transmission and expression.

Claim – Written or electronic proof — in a form We accept — of charges for Covered Services that a Member receives when the Member is insured under this Plan. The provisions that are in effect when You receive the service or treatment will govern how We process any Claim.

Coinsurance – A share of the costs for services that this Plan covers. This amount is calculated as a percentage — a percentage that We pay and percentage that You pay. (For example, We pay 80% for a service and You pay 20%.)

Company – Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company). We may use common words to describe the Benefits provided under this Contract. *We*, *Us*, and *Our* mean Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Company.

Complaint – An oral expression of dissatisfaction with Us or a Provider service.

Complication(s) – A medical condition, arising from an adverse event or consequence, which requires services, treatment or therapy and which is determined by BCBSLA, based on substantial medical literature and experience, to be a direct and consequential result of another medical condition, disease, service or treatment. Solely as an example, a pulmonary embolism after Surgery would be a Complication of the Surgery.

Congenital Anomaly – A condition existing at or from birth, which is a deviation from the common form or norm. Only deviations that impact bodily functions are covered. Examples of Congenital Anomalies that do not impact bodily function and are not covered include, but are not limited to: protruding ears, birthmarks, webbed fingers and toes, and asymmetrical breasts. Cleft Lip and Cleft

Palate are covered Congenital Anomalies; other conditions relating to teeth or structures supporting the teeth are not covered. We will determine which conditions are covered as Congenital Anomalies.

Consultation – Another Physician's opinion or advice about Your evaluation or treatment which is given after the attending Physician asks for it. *Consultations* do not include the following:

- Those that Hospital rules and regulations require,
- Anesthesia Consultations,
- Routine Consultations for clearance for Surgery, or
- Those between colleagues who share medical opinions as a matter of courtesy and normally without charge.

Contract – This agreement, including the *Application for Individual Coverage*, *Schedule of Benefits*, amendments, and endorsements, if any, that entitle the Subscriber and any Dependents to Benefits. We also call it the *Plan*.

Contract Date – The date on which We issued this Contract to You.

Controlled Dangerous Substances – A drug, substance, or immediate precursor, included in schedules I through V of the Controlled Substances Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Cosmetic Surgery – Any operative procedure, treatment, or service, or any portion of an operative procedure, treatment or service performed primarily to improve physical appearance. An operative procedure, treatment, or service is not considered Cosmetic Surgery if it restores bodily function or corrects deformity to restore function of a part of the body that an Accidental Injury, disease, disorder or covered Surgery has altered.

Covered Disease – Any type or kind of Cancer, Poliomyelitis, Leukemia, Diphtheria, Tetanus, Spinal Meningitis (*Meningococci*), Scarlet Fever, Small Pox, Polio, Tularemia, Encephalitis (*Sleeping Sickness*), Rabies, and Sickle Cell Anemia.

Covered Service – Services or supplies specified in this Plan for which You may receive Benefits if a Provider gives them.

Custodial Care – Treatment or services, regardless of who recommends them or where they are provided, that could be given safely and reasonably by someone who is not medically skilled, or that are designed mainly to help patients with daily living activities. These activities include, but are not limited to:

- Providing personal care, homemaking, moving the patient;
- Acting as companion or sitter;
- Supervising medication that can usually be self-administered;
- Treating or providing services that anyone may be able to perform with minimal instruction; or
- Providing long-term treatment for a condition of a patient who is not expected to improve or recover.

We determine which services are *Custodial Care*.

Dental Care and Treatment – All procedures, treatment, and Surgery that is considered to be within the scope of the practice of dentistry. *Dentistry* is a practice in which a person:

- Is represented 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;
- Takes impressions of the human teeth or jaws or performs any phase of any operation incident to replacing a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or
- 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.

Dependent – A person — other than the Subscriber — whom We have accepted for coverage as shown in the *Schedule of Eligibility*.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures that We recognize as accepted medical practice, given because of specific symptoms, and which are directed toward detecting or monitoring a definite condition, illness, or injury. A Provider must order a Diagnostic Service before it is delivered.

Durable Medical Equipment – Items and supplies used to serve a specific therapeutic purpose in treating an illness or injury. The equipment must be:

- able to withstand repeated use;
- generally not useful to someone who does not have an illness, injury, or disease; and
- appropriate for use in the patient's home.

Effective Date – The date coverage begins under this Plan. The 60-day *Waiting Period* begins on the Effective Date.

Elective Admission – Any Hospital Admission — whether it is for medical or surgical care — for which a reasonable delay will not unfavorably affect the outcome of the treatment.

Emergency – See *Emergency Medical Condition*.

Emergency Admission – An Inpatient Admission to a Hospital that results from an Emergency Medical Condition.

Emergency Medical Condition (or **Emergency**) – A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson who acts reasonably and possesses an average knowledge of health and medicine, to believe that not receiving immediate medical attention could reasonably be expected to result in:

- Seriously jeopardizing the health of the person, or if a woman is pregnant, the health of the woman or her unborn child;
- Seriously impairing bodily function; or
- Causing serious dysfunction of any bodily organ or part.

Emergency Medical Services – Those services that are necessary to screen, evaluate, and stabilize an Emergency Medical Condition.

Gene Therapy - A treatment involving the administration of genetic material to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use.

Grievance – A written expression of dissatisfaction with Us or with Provider services.

Home Health Care – Health services given in someone's home by an organization that We approve and that the appropriate state agency licenses as a Home Health Care agency. At the written direction of a licensed Physician, these organizations primarily provide skilled nursing services by or under supervision of a Registered Nurse who is licensed to practice in the state.

Hospice Care – An integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Members and their families during the final stages of a terminal illness. A Physician directs an interdisciplinary team that centrally coordinates a full scope of health services. A Hospice Care agency that We approve provides the services and supplies.

Hospital – An institution that the appropriate state agency licenses as a general medical surgical Hospital. *Hospital* may also include an institution that primarily provides acute care, skilled nursing, psychiatric, chemical dependency, rehabilitation, skilled nursing, long-term, intermediate, and other specialty care.

Infertility – The inability of a couple to conceive after 1 year of unprotected intercourse.

Inpatient – A Member who is admitted to the Hospital as a registered bed patient and for whom a Bed, Board, and General Nursing Service charge is made. An Inpatient's medical symptoms or condition must require a Physician or nurse to intervene continuously, 24 hours a day. If the services can be safely provided as an Outpatient, a Member does not meet the criteria to be an Inpatient.

Lifetime Maximum Payment – Under this Plan, the most We will pay on Your behalf for all medical Benefits, or for all Benefits payable for certain Covered Services, as shown in the *Schedule of Benefits*.

Member – A Subscriber or a Dependent who is enrolled in this Plan. We may use common words in this Plan to describe the Benefits it provides. *You*, *Your*, and *Yourself* mean the Subscriber or enrolled Dependent.

Mental Disorder (*Mental Health*) – A clinically significant behavioral and psychological syndrome or pattern. This includes to:

- psychoses,
- neurotic disorders,
- personality disorders,
- affective disorders, and
- the following specific severe mental illnesses defined by La. R.S. 22:1043:
  - schizophrenia or schizoaffective disorder;
  - bipolar disorder;
  - panic disorder;
  - obsessive-compulsive disorder;
  - major depressive disorder;
  - anorexia and bulimia;
  - intermittent explosive disorder;
  - post-traumatic stress disorder;
  - psychosis NOS when diagnosed in a child under 17 years of age;
  - Rett's Disorder; and
  - Tourette's Disorder,
- and conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic Mental Disorders that We determine.

The definition of *Mental Disorder* will be the basis for determining Benefits, despite whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

Negotiated Arrangement ("Negotiated National Account Arrangement") – An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard® Program.

Newly Born Infant (or **Newborn**) – Infants from birth until 1 month old or until they are well enough to be discharged to home from a Hospital or neonatal Special Care Unit, whichever period is longer.

Occupational Therapy – Evaluating and treating physical injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by using specific goal-directed activities, therapeutic exercises, or other interventions that alleviate an impairment or improve functional performance. These can include:

- designing, fabricating, or applying Orthotic Devices;
- training in using orthotic and prosthetic devices;
- designing, developing, adapting, or training in using assistive devices; and
- adapting environments to help functional performance.

Orthotic Device – A rigid or semi-rigid supportive device which restricts or eliminates the motion of a weak or diseased body part.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Over-Age Dependent – A Dependent Child (or Grandchild) who is age 26 or older, reliant on Subscriber for support, and is incapable of sustaining employment because of an intellectual or physical disability that began prior to age 26. Coverage of the Over-Age Dependent may continue after age 26 for the duration of incapacity if, prior to or within thirty-one (31) days of the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending Physician is submitted to Company. Company may require additional or periodic medical documentation regarding the Dependent Child's intellectual or physical disability as often as it deems necessary, but not more frequently than once per year after the two year period following the child's 26th birthday. Company may terminate coverage of the Over-Age Dependent if Company determines the Dependent Child is no longer reliant on Subscriber for support or is no longer intellectually or physically disabled to the extent, he is incapable of sustaining employment.

Pharmacy Benefit Manager (PBM) – A third party administrator of Prescription Drug programs.

Physical Therapy – Treating disease or injury by using therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Physician – A Doctor of Medicine or a Doctor of Osteopathy who is legally qualified and licensed to practice medicine and is practicing within the scope of that license at the time and place service is given.

Plan – See *Contract*.

Policy Year – The 12-month period beginning with the Effective Date of this Contract or the anniversary of this date, and ending on the day before the next anniversary of the Effective Date.

Prescription Drugs – Medications, including Specialty Drugs, for which legally selling or dispensing them requires an order from a Physician or other healthcare professional. These drugs carry the federally required product legend stating that they may not be dispensed without a prescription. The United States Food and Drug Administration currently approves prescription drugs for safety and effectiveness. Coverage for prescription drugs is subject to the details stated in *Article 9: When Won't the Plan Pay? Limitations and Exclusions*.

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage, or adoption. The attending Physician must order these services. These services must also require the technical skills of an RN or LPN.

We determine which services are Private Duty Nursing Services. Private Duty Nursing Services that are determined by Us to be Custodial Care are not covered.

Prosthetic Appliance – Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider – A Hospital, Allied Health Facility, Physician, or Allied Health Professional that We approve, is licensed where required, and performs within the scope of that license. If a Provider does not have a state or federal license, We have the right to define all criteria under which the Provider may offer services to Our Members for Benefits to apply to a Provider's Claims. If Providers who do not meet these criteria submit Claims, We will not pay them.

Provider Incentive – An additional amount of compensation paid to a healthcare Provider by a payer, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group or population of covered persons.

Rehabilitative Care – Coordinated use of medical, social, educational, or vocational services — beyond the acute care stage of disease or injury — to upgrade the physical functional ability of a patient who is disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

Skilled Nursing Facility or Unit – A facility licensed by the state or in a unit within a Hospital, other than a nursing home, that provides:

- Inpatient medical care, treatment, and skilled nursing care as defined by Medicare and which meets Medicare's requirements for this type of facility;
- Full-time supervision by at least 1 Physician or Registered Nurse;
- Twenty-four-hour nursing service by Registered Nurses or Licensed Practical Nurses; and
- Utilization review plans for all patients.

Special Care Unit – A designated Hospital unit which We approve and which has concentrated all facilities, equipment, and supportive services to provide an intensive level of care for critically ill patients.

Specialty Drugs – Biotechnology drugs or other drug products that may require special ordering, handling, or customer service. Examples include protein drugs, monoclonal antibodies, interferons, antisense drugs, epidermal growth-factor inhibitors, and gene therapies.

Speech/Language Pathology Therapy – The Treatment used to manage speech/language, speech/language development, cognitive communication, and swallowing disorders. The therapy must be used to improve or restore function.

Subscriber – Someone who is a resident of this state, who has satisfied the specifications of this Plan's *Article 3: Schedule of Eligibility,* who signed the *Application for Individual Coverage* or had an appropriate legal representative sign the application for him, who has enrolled for coverage, and to whom We have issued a Contract.

Surgery – The term *Surgery* includes:

- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, incisional and excisional biopsies, and other invasive procedures;
- The correction of fractures and dislocations;
- Usual and related pre-operative and post-operative care; and
- Other procedures that We define and approve.

Temporomandibular/Craniomandibular Joint Disorder – Disorders resulting in pain or dysfunction of the temporomandibular/craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes.

Urgent Care – A sudden, acute and unexpected medical condition that requires timely diagnosis and treatment but does not pose an immediate threat to life or limb. Examples of Urgent Care include, but are not limited to, colds and flu, sprains, stomach aches and nausea. Urgent Care may be accessed from an Urgent Care Center if a Member requires non-Emergency medical care or Urgent Care after a Physician's normal business hours.

Urgent Care Center –A clinic with extended office hours which provides Urgent Care to patients on an unscheduled basis without need for an appointment. The Urgent Care Center does not provide routine follow-up care or wellness examinations and refers patients back to their regular Physician for such routine follow-up and wellness care.

Value-Based Program (VBP) – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Waiting Period – The 60-day period after the Effective Date during which We will not pay Benefits for any services, supplies, or treatment.

Article 3. Schedule of Eligibility

ANY ELIGIBILITY REQUIREMENT LISTED IN THIS PLAN THAT IS NOT MANDATED BY STATE OR FEDERAL LAW MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.

A. Who Can Receive Benefits with this Plan?

1. **Subscriber**. A Subscriber is someone who signed or had an appropriate legal representative sign the *Application for Individual Coverage*, and whose application We have accepted. The Subscriber must be a resident of Louisiana.

2. **Dependent**. To be considered Your *Dependent*, someone must meet the criteria listed below when You apply. To be able to keep their coverage, Dependents must continually meet that criteria. If they do not, they may no longer be eligible to be a Dependent and their Benefits may end as this Plan describes. Your Dependents qualify for coverage with this Plan if they are:

    a. **Spouse**: Your legal spouse.

    b. **Children:** A child who is younger than 26 years old and who is one of the following:

        (1) Your child by birth; or

        (2) A child who is legally placed for adoption with You; or

        (3) A child You legally adopted; or

        (4) A child for whom You or Your legal spouse has legal custody or provisional custody by mandate, or for whom You or Your legal spouse is a court-appointed tutor; or

        (5) A child You support according to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or

        (6) Your stepchild; or

        (7) Your grandchild living with You for whom You have legal custody or provisional custody by mandate of the grandchild; or

        (8) Your child or Your grandchild for whom You have legal custody and who is living with You, or who is covered on the Plan before turning 26, and is able to remain covered on the Plan once turning age 26 because he meets the definition and requirements of an Over-Age Dependent.

Who May This Plan Cover?	
A Subscriber...........	You, the policyholder
Your Dependents....	Your legal spouse Your children who meet the criteria below

Subscribers and Dependents are both called *Members*.

B. How Is Someone Covered Under this Plan?

This Plan has a 60-day Waiting Period. That means We will not pay Benefits for any services, supplies, or treatment until 60 days after the Effective Date of the Plan.

1. To apply for this Plan, You filled out the *Application for Individual Coverage.* You may have also included Dependents on that application.

2. For coverage to be effective for You or for any family members, We must first approve Your application. To show that We have approved Your application, We will send You an identification card or other notice. Even if You already paid a premium, coverage for You and any family members on Your application will not begin until We send Our approval. If We do not send You an identification card or written approval, We will only owe You a refund of the amount of premiums You paid.

3. **We offer different classes of coverage with this Plan.** The classes are as follows:

    a. *Subscriber Only* coverage — for You only.

    b. *Subscriber and Spouse coverage* — for You and Your spouse.

    c. *Subscriber and Family* coverage — for You, Your spouse, and 1 or more Dependent children.

    d. *Subscriber and Children* coverage — for You and 1 or more Dependent children.

Which Classes of Coverage Are Possible with This Plan?	
Subscriber Only	For You only
Subscriber and Spouse	For You + Your spouse
Subscriber and Family	For You, Your spouse, + one or more children
Subscriber and Children .... **......................................**	For You + one or more children

4. After We have approved Your application and You have paid any premiums owed, We will assign an Effective Date. Your coverage will begin on that date, but this Plan has a 60-day Waiting Period. That means We will not pay Benefits for any services, supplies, or treatment until 60 days after the Effective Date.

5. **What to do when You have a baby**:

    a. If You have a *Subscriber Only* or a *Subscriber and Spouse* Plan and You have a baby, the following will apply:

        (1) Your Plan will automatically cover Your child for the first 30 days after the baby is born or until the baby is well enough to go home from the Hospital or neonatal Special Care Unit, whichever is longer. We call this the *automatic coverage period*. The baby will be automatically covered by the mother's plan, if she has one. If she does not have a Plan, then the baby will be automatically covered by the father's Plan, only if he has notified Us that the baby was born. If You want to continue coverage for Your child, You must fill out an *Individual Change of Status Card.* We must receive the card within

30 days after the baby is born, and You must pay Your premiums when You receive the bill.

(2) If We do not receive the completed *Individual Change of Status Card* within the automatic coverage period, coverage for Your baby will end under this Plan. If You later decide to add Your child to this Plan, You must prove that Your child is insurable. We may adjust Your premiums when You add Your child to this Plan. Coverage for Your baby will be effective on the first billing date after We approve the evidence that Your baby is insurable.

b. If You have a *Subscriber and Family* or *Subscriber and Children* Plan and You have a baby, the Effective Date for coverage will be the date Your baby is born. Within 180 days after Your baby is born, You must notify Us to update Our records.

6. **What to do if You adopt a Newborn**

a. If You have a *Subscriber Only* or *Subscriber and Spouse* Plan and if, within 30 days after the baby is born, the child is either legally placed in Your home for adoption after a voluntary act of surrender becomes irrevocable, or You have a court order awarding custody to You, the following will apply:

(1) The Newborn will be covered automatically for 30 days. The 30-day period begins on the date the baby is legally placed in Your home or from the date of the custody order — or if the Newborn is ill, from the date the baby could have been legally placed in Your home had the baby not been ill, or until the child is well enough to go home from the Hospital or neonatal Special Care Unit, whichever is longer. If You want to continue coverage for the child without having to prove that the baby is insurable, within 30 days after the child is legally placed in Your home, You must fill out an *Individual Change of Status Card.* Send it to Us and pay Your premium when You receive the bill.

(2) If We do not receive the completed *Individual Change of Status Card* within the automatic coverage period, coverage for Your baby will end under this Plan. If You later decide to add Your child to this Plan, You must prove that Your baby is insurable. Coverage for Your child will be effective on the first billing date after We approve the evidence that Your baby is insurable.

b. If You have a *Subscriber and Family* or *Subscriber and Children* Plan, Your adopted newborn will be covered within 30 days after the baby is born, if the baby is either legally placed in Your home for adoption after a voluntary act of surrender becomes irrevocable — or if the baby is ill, from the date the child could have been legally placed in Your home had the baby not been ill, or You have a court order awarding custody to You. The Effective Date for the child's coverage will be the date the child is placed in Your home or the date of the custody order. Within 180 days of that date, You must notify Us to update Our records.

7. **How to add new Dependents to Your Plan**

To add Dependents that You did not list on Your *Application for Individual Coverage,* fill out the medical questionnaire portion on the *Individual Change of Status Card*. If We accept them, We will assign Your new Dependents the next available Effective Date. This provision does not apply to Newborns.

8. **How to add Adopted Children who are not Newborns to Your Plan**

At any time, You may apply to add to Your Plan Adopted Children who are not Newborns and children who are placed in Your custody. You must fill out the medical questionnaire portion on the *Individual Change of Status Card* and send it to Us. If We accept Your child for coverage, We will assign the next available Effective Date, which will not be before the following:

a. For a legally adopted child, the date of the first court decree of adoption.

b. For a child legally placed in Your home for adoption after a voluntary act of surrender becomes irrevocable, the date the child is placed in Your home.

c. For a child placed in Your custody, the date the court order awarding custody is legally effective.

Article 4. Your Benefits for Cancer and Serious Diseases

ANY BENEFIT LISTED IN THIS PLAN THAT IS NOT MANDATED BY STATE OR FEDERAL LAW MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.

A. About Your Agreement

All Benefits in this Plan are limited, as We show You on the *Schedule of Benefits* and other parts of this Contract. Your *Schedule of Benefits* tells You specific financial information about Your Plan.

It tells You the percentage of Allowable Charges We pay when You have Covered Services. It includes the Lifetime Maximum Payment amounts.

This Plan covers You if You receive treatment for the following Covered Diseases:

- Cancer (any type or kind)
- Poliomyelitis
- Leukemia
- Diphtheria
- Tetanus
- Spinal Meningitis (*Meningococci*)
- Scarlet Fever
- Small Pox
- Polio
- Tularemia
- Encephalitis (Sleeping Sickness)
- Rabies
- Sickle Cell Anemia

When You file a Claim, first We figure the amount We pay as Our Coinsurance percentage of the Allowable Charges for Covered Services. Then We will pay Benefits, up to the maximum amount for Your lifetime.

To be covered by this Plan, an attending Physician must prescribe the services to treat the Member's Covered Diseases. The Plan does not cover other illnesses.

Under certain circumstances, if We learn that We mistakenly paid a Provider amounts that You should have paid — such as if We paid part of Your Coinsurance —We may collect those amounts directly from You. You agree that We have the right to do so.

B. Your Plan Limits How Much We Will Pay Over Your Lifetime

Your Plan limits how much We will pay over Your lifetime. We call that the *Lifetime Maximum Payment.* Each Member in Your Plan may have a separate Lifetime Maximum Payment.

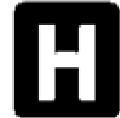
Your Plan may also limit how much We will pay for a particular Covered Service over Your lifetime. To learn about the limits for Your Plan, see the *Schedule of Benefits*.

C. Your Plan Will Pay Benefits After the Waiting Period

This Plan has a 60-day Waiting Period. That means We will not pay Benefits for any services, supplies, or treatment until 60 days after the Effective Date of the Plan. We will pay Benefits for Covered Services according to the Coinsurance percentages shown in the *Schedule of Benefits*.

Article 5. Benefits When You Go into a Hospital

Coinsurance means that we both share the costs of Your healthcare. When a Hospital gives You Covered Services, We will pay Our Coinsurance percentage of the Allowable Charge and You must pay Your percentage. To find out what those percentages are, see the *Schedule of Benefits*.



If You or one of Your Dependents goes to a Physician in a Hospital-based clinic**, the Physician or clinic and the Hospital facility may charge You separately.**

If You or one of Your Dependents goes to a Hospital for Covered Services, this Plan will pay for the following services:

A. Inpatient Bed, Board, and General Nursing Service

1. Hospital room and board and general nursing services.
2. A Special Care Unit if a critically ill Member requires an intensive level of care.
3. A Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital.

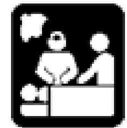
B. Other Hospital (Inpatient and Outpatient)

1. Use of operating, recovery, and treatment rooms and equipment.
2. Drugs and medicines including Prescription Drugs to take home.
3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment, and supplies.

4. Anesthesia, anesthesia supplies, and anesthesia services that a Hospital employee gives.
5. Medical and surgical supplies, casts, and splints.
6. Diagnostic Services that a Hospital employee gives.
7. Physical Therapy that a Hospital employee provides.
8. X-ray and laboratory services.
9. Radiation and chemotherapy.

Article 6. Your Medical and Surgical Benefits

Coinsurance means that we both share the costs of Your healthcare. When You receive covered Medical and Surgical Benefits, We will pay Our Coinsurance percentage of the Allowable Charge and You must pay Your percentage. To find out what those percentages are, see the *Schedule of Benefits*.



This Plan pays Benefits for the following Medical and Surgical services:

A. Surgical Services

1. Surgery
    a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits.
    b. The pre-operative and post-operative period is defined and determined by Us and is that period of time which is appropriate as routine care for the particular surgical procedure.
    c. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.
2. Multiple Medical or Surgical Services - When Medically Necessary multiple services (concurrent, successive, or other multiple medical or surgical services) are performed at the same encounter, Benefits will be paid as follows:
    a. Primary Service
        (1) The primary or major service will be determined by Us.

(2) Benefits for the primary service will be based on the Allowable Charge.

b. Secondary Service

A secondary service is a service performed in addition to the primary service as determined by Us. The Allowable Charge for any secondary service will be based on a percentage of the Allowable Charge that would be applied had the secondary service been the primary service.

c. Incidental Service

(1) An incidental service is one carried out at the same time as a primary service as determined by Us.

(2) Covered incidental services are not reimbursed separately. The Allowable Charge for the primary service includes coverage for any incidental service. If the primary service is not covered, any incidental service will not be covered.

d. Unbundled Services

(1) Unbundling occurs when two (2) or more service codes are used to describe a medical or surgical service performed when a single, more comprehensive service code exists that accurately describes the entire medical or surgical service performed. The unbundled services are considered included in the proper comprehensive service code as determined by Us.

(2) The Allowable Charge of the comprehensive service code includes the charge for the unbundled services. We will provide Benefits according to the proper comprehensive service code, as determined by Us.

e. Mutually Exclusive Services

(1) Mutually exclusive services are two (2) or more services that usually are not performed at the same operative session or encounter on the same patient, on the same date of service, and for which separate billings are made. Mutually exclusive services may also include different service codes and descriptions for the same type of services in which the Physician should be submitting only one (1) of the codes. One or more of the duplicative services is not reimbursable as it should be reimbursed only one time.

(2) The Allowable Charge includes all services performed at the same encounter. Any and all services which are not considered Medically Necessary will not be covered.

3. Assistant Surgeons

The following professionals may be called *assistant surgeons*:

- Physicians,
- licensed physician assistants,
- certified registered nurse first assistants (CRNFA),
- registered nurse first assistants (RNFA), or
- certified nurse practitioners.

We will pay for assistant surgeons' work only if nationally established guidelines require using an assistant surgeon. We base Allowable Charges for assistant surgeons on a percentage of the fee paid to the primary surgeon.

4. Anesthesia

This Plan will pay for general anesthesia services for covered surgical services when:

- the operating Physician requests them, and
- they are performed by a certified registered nurse anesthetist or Physician who is not the operating Physician or assistant surgeon.

This Plan also covers other forms of anesthesia services that We define and approve. Medical direction or supervision of anesthesia administration includes care before, during, and after the Surgery.

Unless We determine otherwise, this Plan pays for anesthetic or sedation procedures performed as a part of the surgical or diagnostic procedure by the operating Physician, assistant surgeon, or advanced practice registered nurse.

We will pay Our Coinsurance percentage of the Allowable Charge based on the primary surgical procedure. We will pay Benefits for the anesthesiologist or certified registered nurse anesthetist who performs the service. When an anesthesiologist medically directs or supervises the certified registered nurse anesthetist, We may divide the payment between the two services, if they are billed separately.

5. Second Opinions About Surgery

You do not need to get second or third opinions to receive Benefits. But this Plan covers consultation and directly related Diagnostic Services to confirm whether You need elective Surgery. If You get second or third opinions, do not get them from the same Physician who first recommended the elective Surgery.

B. Inpatient Medical Services

1. Inpatient medical care visits.
2. Consultation, as defined in this Plan. See *What Terms Do We Use in this Plan?*

C. Outpatient Medical Services and Surgical Services

1. Home, office, and other Outpatient visits to treat Covered Diseases.
2. Consultation.

3. Diagnostic Services.

4. Services of an Ambulatory Surgical Center.

5. Allied Health Facility or Urgent Care Center.

6. Radiation and chemotherapy.

7. X-ray and laboratory services.

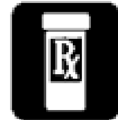
8. Anesthesia supplies and anesthesia services that a Hospital employee gives.

9. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment, and supplies.

10. Medical and Surgical Supplies, casts, and splints.

Article 7. Your Benefits for Prescription Drugs

This Plan only covers Prescription Drugs to treat Covered Diseases as defined in this Plan.



A. The Prescription Drugs Must Be Dispensed After the Waiting Period Ends.

This Plan has a 60-day Waiting Period. That means We will not pay Benefits for any Prescription Drugs until 60 days after the Effective Date of the Plan.

The Plan pays for Prescription Drugs:

- That a Physician or other Allied Health Professional prescribes, and
- For which a licensed pharmacist or a pharmacy technician who is working under the direction of a licensed pharmacist fills the prescription.

B. Our Drug Utilization Management Program Promotes Safe Drug Use

Our Drug Utilization Management Program features a set of closely aligned programs that promote safe, appropriate, and cost-effective use of drugs and that monitor healthcare quality.

C. Prescription Drugs Purchased Outside of the United States Have Restrictions

If You buy Prescription Drugs outside of the United States, they must be equivalent to drugs that require a prescription by United States federal law.

If You buy covered Prescription Drugs and supplies outside of the United States, fill out Our *Prescription Drug Claim Form* and submit it.

For information about how to file Claims for foreign Prescription Drug purchases, call Us at:

1-800-599-2583 or 1-225-291-5370

D. We May Disclose Information About Your Prescription Drug Use

As part of Our procedure to administer Prescription Drug Benefits, We may disclose information about Your Prescription Drug use, including the names of the Physicians who prescribe the drugs, any treating Physicians, or dispensing pharmacies.

E. We Use Savings or Rebates from Drug Manufacturers

If We receive savings or rebates from drug manufacturers for the cost of drugs purchased under this Contract, We use them to stabilize rates.

Article 8. Your Benefits for Other Services, Supplies, or Equipment

We will pay Our Coinsurance percentage of the Allowable Charge for when You receive Covered Services and You must pay Your percentage. To find out what those percentages are, see the *Schedule of Benefits*.

A. Ambulance Service

1. Your Plan pays for Ambulance Services for local transportation if You are admitted as an Inpatient for a Covered Disease in the following instances:
    a. When transportation is needed to travel to or from a Hospital.
    b. If police or medical authorities at the site in an Emergency ask for an air ambulance or if You are in a location that a ground ambulance cannot reach.
2. Your Plan does not pay for Ambulance Services in the following instances:
    a. If transportation is only for Your comfort or convenience,
    b. When a Hospital transports You between parts of its own campus or between facilities owned or affiliated with the same entity, or
    c. If the transportation is not related to treating a Covered Disease.

B. Breast Reconstructive Surgery Services

1. If You receive Benefits in connection with a mastectomy and You choose to have breast reconstruction, Your Plan will pay for the following Covered Services:
    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
2. You will consult with Your attending Physician about receiving these Covered Services.

C. Chiropractic Services

1. Your Plan pays for Chiropractic Services when a chiropractor who is licensed and practicing within the scope of that license performs them.

2. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices to rehabilitate a patient and may order diagnostic tests that are necessary to determine conditions associated with the functional integrity of the spine.

D. Disposable Medical Equipment or Supplies

Your Plan pays for disposable medical equipment or supplies that are related to and necessary to administer Prescription Drugs, such as syringes and needles, and other disposable medical equipment or supplies which have a primary medical purpose. We will determine reasonable quantity limits for them.

E. Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances

1. Durable Medical Equipment

   a. Your Plan covers Durable Medical Equipment when a Physician prescribes the equipment before You get it. The equipment must not be mainly for the comfort or convenience of the Member or others. In addition, the equipment must meet all of the following criteria. It must be:

      (1) Able to withstand repeated use;

      (2) Primarily and customarily used for a medical purpose;

      (3) Generally not useful to someone who does not have the disease or injury; and

      (4) Appropriate for use in the patient’s home.

   b. Your Plan pays to rent or buy Durable Medical Equipment

      (1) We will base Benefits for renting the equipment on Our rental Allowable Charge (but Benefits will not be more than the purchase Allowable Charge).

      (2) If We choose, Your Plan will pay for buying Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use.

      (3) When Durable Medical Equipment is approved by Us, Benefits for standard equipment will be provided toward any deluxe equipment.

Deluxe equipment or deluxe features and functionalities of equipment are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for Your comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

(4) We consider accessories and medical supplies that are necessary for covered Durable Medical Equipment to effectively function to be an integral part of the rental or purchase allowance. Your Plan will not cover them separately.

(5) Your Plan pays to repair or adjust purchased Durable Medical Equipment or to replace components. Your Plan will not pay to replace equipment that is lost or damaged due to neglect or misuse. You Plan will also not pay for replacing equipment that was bought or rented less than five (5) years ago that is not Medically Necessary as determined by Us. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment subject to a recall within five (5) years after purchase or rental will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

c. Limitations in connection with Durable Medical Equipment

(1) When You rent Durable Medical Equipment, Your Plan does not pay to repair, adjust, or replace components and accessories necessary for the effective function and maintenance of covered equipment because this is the responsibility of the Durable Medical Equipment supplier.

(2) Your Plan does not pay for equipment if a commonly available supply or appliance effectively serves the same purpose.

(3) Your Plan does not pay to repair or replace equipment that is lost or damaged due to neglect or misuse.

(4) We will determine reasonable quantity limits on Durable Medical Equipment items and supplies.

(5) Regardless of Claims of Medical Necessity, deluxe equipment or deluxe features and functionalities of equipment that are not approved by Us are not covered.

2. Orthotic Devices

As specified in this section, Your Plan will pay to buy Orthotic Devices. These Benefits will be subject to the following:

a. Your Plan does not pay for fitting or adjustments because this is included in the Allowable Charge for the Orthotic Device.

b. Your Plan pays to repair or replace Orthotic Devices only within a reasonable time-period after You bought them, subject to the expected lifetime of the devices. We will determine that time-period. Regardless of Medical Necessity, repair or replacement of the device will not be covered when provided under warranty or when the device is subject to a recall.

c. When Orthotic Devices are approved by Us, Benefits for standard devices will be provided toward any deluxe device.

Deluxe devices or deluxe features and functionalities of devices are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for Your comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

d. Regardless of Claims of Medical Necessity, deluxe devices or deluxe features and functionalities of devices that are not approved by Us are not covered.

e. No Benefits are available for supportive devices for the foot.

3. Prosthetic Appliances

You Plan will pay to buy Prosthetic Appliances. These Benefits will be subject to the following:

a. Your Plan does not pay to fit or adjust appliances because as this is included in the Allowable Charge for the Prosthetic Appliance.

b. Your Plan pays to repair or replace Prosthetic Appliances only within a reasonable time-period after You bought them, subject to the expected lifetime of the appliance. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of appliances will not be covered when provided under warranty or when the appliance is subject to a recall.

c. When Prosthetic Appliances are approved by Us, Benefits for standard appliances will be provided toward any deluxe appliance.

Deluxe appliances or deluxe features and functionalities of appliances are those:

(a) that do not serve a medical purpose;

(b) that are not required to complete daily living activities;

(c) that are solely for Your comfort or convenience; or

(d) that are not determined by Us to be Medically Necessary.

d. Regardless of Claims of Medical Necessity, deluxe appliances or devices or deluxe features and functionalities of appliances or devices that are not approved by Us are not covered.

F. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services when rendered for a covered condition only when SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM COMPANY TO PERFORM YOUR PROCEDURE.

G. Hospice and Home Health Care Benefits

1. Your Plan pays for Hospice Care only when it is performed in a Hospital or Allied Health Facility.

2. Your Plan pays for Home Health Care services if they are provided instead of an Inpatient Hospital Admission.

H. Oral Surgery

Coverage is provided only for the following services or procedures; the highest level of Benefits is available when services are performed by a PPO Provider, or by a Provider in the United Concordia Dental Advantage Plus Network or in Blue Cross and Blue Shield of Louisiana's Dental Network. Access these Networks online at **www.bcbsla.com**, or call the customer service telephone number on the ID card for a copy of the directory.

Your Plan covers only the following Oral Surgery services or procedures.

1. Excision of tumors or cysts (not odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof, and floor of mouth.

2. Anesthesia for the above services or procedures when given by an oral surgeon, or by a dentist who holds all required permits or training to administer anesthesia.

3. Anesthesia when given in a Hospital setting and for associated Hospital charges when Your mental or physical condition requires Covered Services to be given in a Hospital setting. Your Plan does not pay for Anesthesia to treat Temporomandibular Joint (TMJ) Disorders.

4. Your Plan pays for dental services that are not otherwise covered when the services are specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To find out if You qualify for these

Benefits, call Customer Service at the phone number on Your ID card, and ask to speak to a Case Manager.

I. Organ, Tissue, and Bone Marrow Transplant Benefits

Because this policy is a limited Benefits policy, You should ask for Our Authorization to evaluate whether You are suitable for all solid organ and bone marrow transplants and procedures. For this Contract, We consider all autologous procedures to be transplants.

Before You are Admitted to a Hospital for a proposed transplant procedure, You or Your Provider should give Us adequate information so that We may check that You are covered.

1. Acquisition Expenses

   If an organ, tissue, or bone marrow is obtained from a living donor for a covered transplant, the Plan will pay for the donor's medical expenses as acquisition costs. The Lifetime Maximum applies to Benefits for covered acquisition expenses. If the donor is a Member of Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. and the Lifetime Maximum has been met on this Plan, the donor's policy may cover medical expenses.

   The Lifetime Maximum applies to costs of searching for bone marrow donors. If any organ, tissue, or bone marrow is sold rather than donated, the Plan does not pay the purchase price.

2. Organ, Tissue, and Bone Marrow Transplant Benefits

   a. We recommend that You go to a Blue Distinction Centers for Transplants (BDCT) or a Blue Cross and Blue Shield of Louisiana (BCBSLA) preferred facility for services for solid organ and bone marrow transplants. To find an approved transplant facility, contact Our Customer Service Department at the phone number on Your ID card.

   b. Benefits for Organ, Tissue, and Bone Marrow Transplants include coverage for immunosuppressive drugs prescribed for transplant procedures.

Benefits as specified in this section will be provided for treatment and care as a result of or directly related to the following transplant procedures:

1. Solid human organ transplants of the:

   a. Liver;

   b. Heart;

   c. Lung;

   d. Kidney;

   e. Pancreas;

f. Small bowel; and

g. Other solid organ transplant procedures which We consider to be standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. We will consider these solid organ transplants on a case-by-case basis.

2. Tissue transplant procedures (autologous and allogeneic), as specified below, are covered:

   a. Blood transfusions;

   b. Autologous parathyroid transplants;

   c. Corneal transplants;

   d. Bone and cartilage grafting;

   e. Skin grafting;

   f. Autologous islet cell transplants; and

   g. Other tissue transplant procedures which We consider to be standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. We will consider these tissue transplants on a case-by-case basis.

3. Bone marrow transplants

   a. Your Plan covers allogeneic, autologous, and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite), and donor lymphocyte infusions.

   b. Your Plan also covers other bone marrow transplant procedures which We consider to be standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. We will consider these bone marrow transplant procedures on a case-by-case basis.

J. Physical Therapy

Your Plan pays for Physical Therapy Benefits when they are provided on an Inpatient or Outpatient basis. The services must be given by a licensed Physical Therapist practicing within the scope of that license. You must be able to tolerate at least 3 hours of active therapy per day.

K. Private Duty Nursing Services

1. Your Plan pays for Private Duty Nursing Services when You are an Inpatient and when the nurse is not related to You by blood, marriage or adoption.

2. Your Plan pays for Private Duty Nursing Services at the Coinsurance level and up to the limitations shown on the *Schedule of Benefits*. The Lifetime Maximum Payment for Inpatient Private Duty Nursing Services will also count toward the Lifetime Maximum Payment for all Benefits.

3. Your Plan does not pay for Outpatient Private Duty Nursing Services.

Article 9. When Won't the Plan Pay? Limitations and Exclusions

ANY LIMITATION OR EXCLUSION LISTED IN THIS PLAN MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.

A. This Plan Pays Only for Services, Supplies, and Treatment that the Contract Covers.

This Plan does not pay for services, supplies, and treatment for diseases that are not covered under this Contract. It also does not pay for complications from services, supplies, and treatments for those diseases.

B. This Plan Will NOT Pay Benefits for Any of the Following:

1. Any charges that are more than the Allowable Charge.

2. Except as otherwise shown in the Plan, incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided using a Special Care Unit.

3. Services, Surgery, supplies, treatment, or expenses:

    a. other than those specifically listed as covered by this Plan or for which You have no obligation to pay, or for which You would not be charged (or a lesser charge would be made) if You had no health insurance coverage. Benefits are available when You receive

Covered Services at medical facilities owned and operated by the State of Louisiana or any of its political subdivisions.

b. given or furnished before the Waiting Period ends or after Your Contract ends. The Plan does not pay for charges for Hospital services or supplies if Your Admission is in progress on Your Effective Date, even though Your Admission continues after Your Effective Date, unless the law requires otherwise. Your Plan will pay for Hospital Benefits if Your Admission is in progress on the date Your Plan ends, until the end of that Admission, or until You have reached any Benefit limitations set in this Contract or *Schedule of Benefits*, whichever occurs first;

c. which a Provider, Physician, or Allied Health Professional who acts outside the scope of his license performs or directs;

d. rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs, including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes whether or not coverage under such laws or programs is actually in force;

e. received from a dental, vision, or medical department or clinic maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust, or similar person or group;

f. given by a Provider who is Your spouse, child, stepchild, parent, stepparent or grandparent; or

g. if You have a history of any Covered Disease or symptoms of any Covered Disease that has shown itself before the Effective Date.

4. Services in the following categories:

   a. for diseases contracted in or injuries sustained as a result of declared or undeclared war, or any act of war;

   b. for injuries or illnesses that the Secretary of Veterans' Affairs finds to have been incurred in or aggravated while serving in the uniformed services;

   c. for those occurring as a result of taking part in a riot or acts of civil disobedience;

   d. to treat You if You are confined in a prison, jail, or other penal institution; or

   e. for those occurring while You were committing or trying to commit a felony. This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. You may receive Benefits for illness or bodily injury due domestic violence or a medical condition (including both physical and mental health conditions) or in case of Emergency care, the initial medical screening examination, treatment, and stabilization of an Emergency Medical Condition.

5. Services, Surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following:

    a. rhinoplasty;

    b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;

    c. gynecomastia;

    d. breast enlargement or reduction, except for breast reconstructive services as specifically provided in this Plan;

    e. implantation, removal, or re-implantation of breast implants and services, illnesses, conditions, complications, or treatment related to or as a result of breast implants;

    f. implantation, removal, or re-implantation of penile prosthesis and services, illnesses, conditions, complications, or treatment related to or as a result of penile prosthesis;

    g. diastasis recti;

    h. biofeedback;

    i. lifestyle or habit-changing clinics or programs;

    j. treatment related to sexual function, sexual dysfunctions, or sexual inadequacies;

    k. industrial testing or self-help programs (such as smoking-cessation programs and supplies, and stress-management programs), work-hardening programs, or functional capacity evaluation, driving evaluations;

    l. Rehabilitative Care including these unless specifically listed as a covered Benefit: recreational therapy; visual therapy, occupational therapy, cardiac rehabilitation, remedial reading, Speech/Language Pathology Therapy;

    m. Inpatient pain rehabilitation or pain-control programs; or

    n. treatment primarily to enhance athletic abilities.

6. Services, Surgery, supplies, treatment, or expenses related to:

    a. routine eye exams, eyeglasses, contact lenses or exams;

    b. eye exercises, visual training, or orthoptics;

    c. hearing aids or examinations to prescribe or fit hearing aids;

    d. hair pieces, wigs, hair growth, or hair implants; or

    e. the correction of refractive errors of the eye, including radial keratotomy and laser Surgery.

7. Services, Surgery, supplies, treatment, or expenses related to:

   a. any costs of donating an organ or tissue for transplant when You are a donor, except as provided in this Plan;

   b. transplant procedures for any human organ or tissue transplant that are not specifically listed as covered. Related services or supplies include administration of high-dose chemotherapy to support transplant procedures;

   c. the transplant of any non-human organ or tissue; or

   d. bone marrow transplants and stem cell rescue (autologous and allogeneic), except as provided in this Plan.

   e. Gene Therapy or Cellular Immunotherapy if the services are performed at an administering Facility that has not been approved in writing by Company prior to services being rendered.

8. Services, Surgery, supplies, treatment or expenses related to:

   a. weight-reduction programs;

   b. removal of excess fat or skin, or services at a health spa or similar facility; or

   c. obesity or morbid obesity.

9. Food or food supplements, low-protein foods, formulas, and medical foods, including those used for gastric tube feedings.

10. Prescription Drugs for the following:

    a. lifestyle-enhancing drugs including, but not limited to, medications used for cosmetic purposes (e.g., Botox®, Renova®, Tri-Luma®), medications used to enhance athletic performance, medications used for effects of aging on the skin, and medications used for hair loss or restoration (e.g., Propecia®, Rogaine®), except for Prescription Drugs approved by Us to treat alopecia areata or alopecia universalis;

    b. any medication not proven to be effective in general medical practice;

    c. fertility drugs;

    d. prescription vitamins that are not listed in Our Prescription Drug formulary (for example, Enlyte®);

    e. nutritional supplements;

    f. drugs that can be lawfully obtained without a Physician's order or that do not require a prescription, including over-the-counter (*OTC*) drugs, except those required to be covered by law;

    g. contraceptive drugs and devices;

h. refills that are more than the number specified by the Physician or the dispensing limitation described in this Plan, or a refill before 75% of the day supply is used, or any refills dispensed more than 1 year after the Physician originally prescribes them;

i. any drugs used for smoking cessation;

j. compounded drugs that exhibit any of the following characteristics:

   (1) are similar to a commercially available product;

   (2) whose principal ingredients are being used for an indication for which no FDA approval exists;

   (3) whose principal ingredients are being mixed together to administer in a manner inconsistent with FDA-approved labeling (for example, a drug approved for oral use that is administered topically);

   (4) compounded drugs that contain drug products or components of drug products that have been withdrawn or removed from the market for safety reasons; or

   (5) compounded prescriptions whose only ingredients do not require a prescription;

k. Prescription Drugs filled before the Waiting Period ends or after Your Plan ends;

l. replacement of lost or stolen Prescription Drugs, or those rendered useless by mishandling, damage, or breakage;

m. Prescription Drugs related to a disease that is not covered;

n. Prescription Drugs, equipment, or substances to treat sexual or erectile dysfunction (for example, Viagra®, Cialis®, Levitra®);

o. medication, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used illegally;

p. growth hormone therapy;

q. Prescription Drugs for or treatment of idiopathic short stature; or

r. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when multiple professionals prescribe them at the same time or where a prescriber agrees that You obtained prescriptions because You misrepresented to that prescriber. Limitation may include that You are required to obtain future Controlled Dangerous Substances from only 1 prescriber and 1 pharmacy.

11. Sales tax or interest, including sales tax on Prescription Drugs.

12. Personal comfort, personal hygiene, and convenience items such as air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to Your home or vehicle.

13. Charges for telephone or e-mail Consultations between You and a Provider, failure to keep a scheduled visit, completion of a Claim form, or to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

14. Palliative or cosmetic care or treatment; and treatment of flat feet, except for Medically Necessary Surgery. Additionally, Benefits for cutting or removal of corns and calluses, nail trimming or debriding, or supportive devices of the foot are available for people who have been diagnosed with diabetes when those services are Medically Necessary.

15. Services or supplies related to diagnosing and treating Infertility such as in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, Your Plan does not pay for these procedures.

16. Services, supplies, or treatment related to artificial means of pregnancy such as in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment.

17. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for services that are not covered.

18. Piercings, procedures, services, supplies, or treatment for cosmetic purposes, Cosmetic Surgery, and any complications resulting from any of these items or any other non-covered items.

19. Dental Care and Treatment and dental appliances except as specifically provided in this Plan under Oral Surgery Benefits.

20. Congenital Anomalies; diagnosis, treatment, or Surgery of dentofacial anomalies including malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible and maxilla, and any orthognathic condition.

21. Medical exams or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp- or school-required examinations.

22. Travel, whether or not a Physician recommends it, and Ambulance Services, except as specifically provided in this Plan, or as approved by Us.

23. Education services and supplies including training or re-training for a vocation, diabetes, diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.

24. Admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting (for example, Outpatient department of a Hospital or Physician’s office).

25. Custodial Care, nursing home or custodial home care, regardless of the level of care.

26. Services or supplies for preventive or wellness care including well baby care.

27. Hospice services provided at a location other than a Hospital or Allied Health Facility.
28. Services or supplies to treat Mental Disorders, alcohol or drug abuse, and eating disorders.
29. Counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, grief counseling, parental counseling, and employment counseling.
30. Any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Plan.
31. Medical and Surgical treatment for snoring including laser-assisted uvulopalatoplasty (LAUP).
32. Paternity tests and tests performed for legal purposes.
33. Genetic testing, unless the results are specifically required for a medical treatment decision about You.
34. Voluntary sterilization procedure or reversal.
35. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits that We determine; all defibrillators other than implantable defibrillators and wearable defibrillators that We authorize.
36. Services, Surgery, supplies, treatment, or costs related to:
    a. Genetic testing, unless the results are specifically required by law or for a decision about a Member's medical treatment,
    b. A genetic diagnosis before implantation,
    c. Carrier screening before conception, and
    d. Prenatal carrier screening, except for cystic fibrosis.
37. Services or supplies to store cord blood prophylactically.
38. Transcutaneous nerve stimulation.
39. Sleep studies.

Article 10. What Else Applies to Your Plan? General Provisions

A. About This Contract

1. **Your Contract has several components:** The entire Contract between Us and You includes Your *Application for Individual Coverage,* expressing the entire money and other consideration; the *Schedule of Benefits*; any riders; and any amendments or endorsements.

2. **This Plan can change:** From time to time, We may change this Plan. If We do change it, the changes usually occur on Your anniversary date. If We choose, We will renew or continue this Plan monthly. Each time You pay Your premium when it is due, You show that You want to continue coverage and move to the current policy form.

3. For this Plan, We have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third parties. Any of Our subsidiaries, affiliates, subcontractors, or designees may perform any of Our functions.

4. Our liability is limited to the Benefits specified in this Contract. We will pay Benefits only for Covered Services and supplies given on and after Your Effective Date by a Provider defined in this Plan.

B. Section 1557 Grievance Procedure

Blue Cross and Blue Shield of Louisiana not to discriminate on the basis of race, color, national origin, sex, age or disability. Blue Cross and Blue Shield of Louisiana has adopted an internal grievance procedure providing for prompt resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Section 1557 Coordinator, who has been designated to coordinate the efforts of Blue Cross and Blue Shield of Louisiana to comply with Section 1557 at the following address:

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

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Blue Cross

and Blue Shield of Louisiana to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

1. Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date You become aware of the alleged discriminatory action.

2. A complaint must be in writing, containing Your name and address. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

3. The Section 1557 Coordinator will investigate the complaint. This investigation may be informal, but it will be thorough. You are encouraged to submit evidence related to Your complaint. The Section 1557 Coordinator will maintain the files and records of Blue Cross and Blue Shield of Louisiana relating to such grievances. To the extent possible, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

4. The Section 1557 Coordinator will issue a written decision on the grievance no later than thirty (30) days after it is received.

5. You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Section 1557 Grievance Administrator shall issue a written decision in response to the appeal no later than thirty (30) days after it is received.

The availability and use of this grievance procedure does not prevent You from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the United States Department of Health and Human Services, Office for Civil Rights. You can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

United States Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-877-696-6775

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within one hundred eighty (180) days of the date of the alleged discrimination.

Blue Cross and Blue Shield of Louisiana will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

C. We Are Not Responsible for Anything Providers Do

We are not 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 Hospital or institution agent or employee, or any Physician, Allied Provider, nurse, technician, or other person who participates in or has to do with Your care or treatment.

D. We Can Change Your Contract

By law, agents may not change the terms of this Contract, other than by amendment or endorsement that We issue. No representation that any agent makes can change the terms of this Contract. To be valid, one of Our executive officers must sign any amendment or endorsement. From time to time, We may change this Plan, usually on its anniversary date.

E. Always Carry Your Identification Card

We will send You an identification card which identifies You as a Member. Your card gives You no right to Benefits. You cannot transfer Your card to anyone else. If You use Your card in an unauthorized way, We can end Your coverage. You must show Your card whenever You receive services. To be entitled to Benefits, Your premium payment must be up to date. If You lose Your card or it is stolen, notify Us immediately.

F. Pay Your Premiums When They Are Due

1. Before You can be covered, You must pay Your premiums. Premiums are due on the Effective Date of the first Policy Year of this Contract and on the same day each month after that. This date is called the *premium due date*. If You pay Your premium on time, We will renew this Plan each month.

2. The Subscriber owes the premiums for this Plan. Third parties may not pay unless they are related to You by blood or marriage. Hospitals, pharmacies, Physicians, or insurance carriers may not pay Your premiums for You. We will not accept payments by third parties unless the law requires Us to do so. If We have accepted a premium from unrelated third parties before, that does not mean that We will accept premiums from them again.

3. If a premium is not paid when it is due, We may agree to accept a late payment, but We are not required to do so. If We accepted a late payment before, that does not mean We will accept late a payment again. Do not rely on the fact that We accepted a late payment before as a sign that We will do so in the future.

4. You must pay Your premiums in U.S. dollars. If the bank returns one of Your checks due to insufficient funds, We will charge You a $25.00-NSF fee. If the bank returns more than one check, We may refuse to reinstate Your coverage.

G. Your Premium Amount Can Change

1. **If Your age was misstated on the application, Your premiums or Benefits can change.** If We learn that You told Us the wrong age, any Benefit You receive will be the daily amount the premiums paid would have purchased at Your correct age. If We issued or renewed this Contract because We believed You were younger than You are and if We would not have issued, continued, or renewed it because You were older, then You will not receive Benefits. We will only return the premium You paid. A clerical error will not void insurance which should be in force nor will it continue insurance which should have ended.

2. **We can increase the premiums for this Plan.** We can increase Your premiums after the first Policy Year (that means after the first 12 months You have this Plan) and then every 6 months after that. At times, Your premiums may increase more frequently as described in the following paragraph. Except as stated in the following paragraph, if We do increase Your premiums, 45 days before the change We will write to You at the last address shown in Our records. In the notice, We will tell You when the increase will occur. Each time You pay Your premium when it is due, You show that You want to continue Your coverage.

3. **At any time during the life of this Contract, We can increase premiums more often than stated above if a change occurs in the extent or nature of the risk that We did not consider when We set the rates.** This risk includes adding a newly covered person. Also, We can increase the premium if You ask Us to change Benefits from those that were in force when We last set the rates. Any increase in premium will begin on the next billing date after the Effective Date of the risk change. Each time You pay Your premium when it is due, You show that You want to continue Your coverage.

H. You Can Cancel This Contract

1. As the Subscriber, You can cancel this Contract for any reason.

2. To cancel, You must write to Us. You cannot cancel this Contract by calling Us.

3. **If You want to cancel, You must write to Us before or on the Effective Date of the cancellation. You must also return this Plan.** If You do not send Us the Plan, We will assume that You tried to find it in good faith and that You either lost it or it was destroyed.

4. To cancel, write to Us at:

Blue Cross and Blue Shield of Louisiana
Individual Membership and Billing
P. O. Box 98029
Baton Rouge, LA 70898-9029

Or fax Us at:

(225) 297-2820

I. We Can End This Contract if You Do Not Pay Your Premium on Time

1. Before You can be covered, Your premiums must be paid. If Your premiums are not paid when they are due, We consider them to be late.

2. You have a thirty (30) day grace period (sometimes called a *delinquency period*) after the due date to pay Your premium. If We receive Your payment within thirty (30) days after the due date, Your coverage will remain in effect during the grace period pursuant to the provisions of the Contract. If We do not receive Your payment at Our home office within thirty (30) days, We will send You a delinquency or lapse notice at the last address shown in Our records telling You that Your payment is late and that Your coverage will lapse. We may also send You a termination notice. If We do not receive Your payment within thirty (30) days of the due date (during the grace period), We may automatically end Your Contract without telling You. If We do so, Your coverage will end on midnight of the last day for which premiums have been paid. We will not pay any Benefits for services given after that date.

3. You agree to pay reasonable costs and fees to Us, including reasonable attorney's fees, for Our attempt to collect any amounts owed under this Contract, including, but not limited to, unpaid premium.

J. We Can End this Contract for Other Reasons

1. We may choose to end or not renew this Contract for any of the following reasons:

   a. If You commit fraud or You intentionally misrepresent material facts. We issued this Contract based on information You gave Us on the *Application for Individual Coverage*; We have attached a copy of it and it is part of this Contract. If You commit fraud, We may end Your Plan at any time. In that case, We will write to tell You that Your Plan has ended. Within 3 years after Your Effective Date, if We learn that You misrepresented or omitted a material fact on Your application that would have caused Us to deny You coverage had We known it, We will end this Contract and will write to tell You that We did. If this Contract ends and You have not received Benefits, We will refund any premiums paid after the Effective Date. If You have already received Benefits, We will subtract the amount of Benefits You received from the amount of premiums that You paid and We will refund the

balance, if one remains. If You enroll someone who is not eligible for this Plan, You commit an act of fraud or You have intentionally misrepresented material facts.

b. If the Subscriber does not meet a material plan provision or obligation, including provisions relating to eligibility.

c. In the case of network plans, if You no longer live, reside, or work in Our service area in or in the service area for which We are authorized to do business.

d. If We no longer offer this Plan in the market.

2. If We end or do not renew this Plan because You commit fraud or intentionally misrepresent facts (as in *a.* above), Your Plan will end immediately when We notify You. If We end or do not renew this Plan because the Subscriber does not meet a provision (as in of *b.* or *c.* above), We will write to You by certified mail 60 days before the Plan ends; We will tell You why We have ended or did not renew it. If We end or do not renew because We no longer offer the Plan, We will write to You by regular mail 90 days before the Plan ends.

K. When Your Coverage Ends

1. All coverage will stop at the end of the period for which premiums have been paid. You will not receive Benefits for services that You receive after Your Plan ends.

2. You have an obligation to notify Us, within 15 days, when Dependents die or need to be taken off this Contract for any reason. We will re-calculate premiums so You pay the proper amount. No refunds will be made to You if You fail to give timely notice when a Dependent ceases to be eligible to keep coverage or when a Dependent's coverage should have been terminated.

3. For Admissions that begin before the Plan ends, Benefits for that Admission will stop when the Admission ends or when You reach any Benefit limit set in this Plan, whichever occurs first.

4. When You receive a final decree of divorce or Your marriage ends for another legal reason, coverage for Your spouse stops automatically, without notice, at the end of the period for which premiums have been paid. You have an obligation to notify Us, within 15 days, after a final divorce or other legal termination of marriage is rendered.

5. Coverage for Dependents stops automatically, without notice, at the end of the month during which they are no longer eligible to be Dependents, if premiums are paid through that month.

6. When the Subscriber dies, the Plan automatically ends for all Dependents. This Plan stops without notice at the end of the billing period in which You die, if premiums have been paid through that billing cycle.

7. If Your spouse or other Dependents wish to continue this Plan, they must notify Us within 30 days after this Plan ends that they want to continue it. If We receive their notice within 30 days of the Plan's end, their coverage will continue and they will not have to prove that they are insurable.

8. We are licensed to sell insurance only in the state of Louisiana. If You move outside of Louisiana and You intend to relocate or live outside of the state, Your Plan will end.

L. How to File Claims

1. A ***Claim*** is written or electronic proof that You were charged for services You received while You were covered under this Plan. You must file Claims within 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 15 months from the date services were rendered. We will not pay Benefits if You or Your Providers file a Claim more than 15 months after You receive services.

2. Contract provisions that are in effect when You receive services or treatments govern how We process Your Claim.

3. When We receive a notice of Claim, We will send You the appropriate forms. If We do not send those forms within 15 days after receiving Your notice, We will consider that You have complied with the Plan's requirements to prove loss within the time fixed in this Plan.

4. To file Claims for Prescription Drug Benefits, You must use the *Prescription Drug Claim Form* or an attachment that We accept. After the form is completed and signed by Your pharmacist, send it to Us at:

   Blue Cross and Blue Shield of Louisiana
   P. O. Box 98029
   Baton Rouge, LA 70898-9029

5. If the laws of the state, district, or territory in which You lived when We issued the Contract give You more time to notify Us, send Us a Claim, or bring suit, then We will extend the time period to follow those laws.

M. Legal Action

1. No lawsuit related to a Claim may be filed any later than twelve (12) months after the Claims are required to be filed.

2. Any and all lawsuits, other than those related to Claims as stated above, must be brought within one (1) year of the end of the Benefit Period.

N. We May Release Information

We may ask that You or Your or Provider send Us certain information, records, or copies of records about Your Claim. We will keep that information confidential except where in Our discretion We must disclose it.

O. Assignment

1. Any rights or Benefits that a Member has under this Plan belong to that Member only; You cannot give them to anyone else. We call that *assignment of Benefits*. You can only assign Your Benefits to Hospitals if both this Plan and the Provider are subject to La. R.S. 40:2010. If both this Plan and the Provider are not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of Benefits. Nothing in the written description of health coverage can be construed to make the Plan or Us liable to any third party to whom You owe the cost of medical care, treatment, or services.

2. To help make care more affordable, We have contracted with a wide range of Providers. If Your Provider files Your Claim for You, We will pay Your Provider directly. If You file Your Claim with Us, We will pay You directly.

P. Your Relationship with Your Provider

1. You may choose which Provider to go to. The choice is Yours only.

2. We are separate from any contracted Providers. We are considered independent contractors; We are not agents, representatives, or employees of one another for any purpose. We do not provide Covered Services; We only pay for the Covered Services You receive. We are not liable for or on account of any act or omission of any Provider. We are not liable for any Claim or demand because of damages that may arise out of, or in any manner connected with, any injuries You may suffer while receiving care from any Provider or in any Provider's facilities. We are also not responsible if a Provider doesn't give or refuses to give You Covered Services.

Q. How the Law Applies

This Contract is governed and construed according to laws and regulations of the State of Louisiana, except when preempted by federal law. If any Contract provision conflicts with any statutes of Louisiana that apply, that provision is automatically amended to meet statutes' minimum requirements. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

R. 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, insurer or other carrier even where such insurer or carrier provides Benefits directly to You who are its insured. The acceptance of such Benefits under this Contract will constitute subrogation. Our right to recover will be contingent on Your right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or a judgment following a trial. We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by You in pursuing recovery.

2. You will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization, insurer or other carrier, even where such insurer or carrier provides Benefits directly to You who are its insured, to the extent of the Benefits provided or paid under this Contract. Our right to recover will be contingent on Your right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or judgment following a trial. 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 interests under this Contract. We and Our designees have the right to obtain and review Your medical and billing records if We determine in Our sole discretion, that such records would be helpful in pursuing Our right of subrogation and reimbursement.

S. We Have the Right of Recovery

If We mistakenly pay more than the Benefits available under this Plan or if We pay for services that are not covered, We can recover that payment from You or Your Provider, if it applies. We can also deduct any amounts that You or Your Provider owe Us from any pending Claim.

T. If a Veteran Goes to a Department of Veterans Affairs or Military Hospital

If the United States Department of Veterans Affairs gives care or services to a veteran for a non-service-connected disability, the United States can recover or collect reasonable costs from Us to the extent that the veteran would be eligible for Benefits from Us had the care or services not been given by a department or agency of the United States. We will reduce the amount that the United States may recover by the appropriate Coinsurance amount.

If a military retiree or Dependent receives care through a facility of the United States military, the United States can collect from Us the reasonable cost of healthcare services incurred to the extent that the person would be eligible to receive reimbursement or indemnification from Us had the

person incurred such cost on his or her own behalf. We will reduce the amount that the United States may recover by the appropriate Coinsurance amount.

U. How Proxy Votes Work

A majority vote of Our policyholders elects Our Board of Directors and determines certain significant corporate transactions, unless the law or Our Articles of Incorporation or Bylaws require a different vote. Through the *Application for Individual Coverage*, Subscribers select members of Our Board of Directors as their proxy to vote. Every time You pay Your premium, You extend that selection unless You revoked it.

To revoke a proxy or name a different proxy, write to Us and include Your name and policy number. Send Your letter to:

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

By telling Your proxy about meetings, We fulfill Our duty to notify You. Also, We are notifying You that the annual Plan meeting occurs 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 Service and Indemnity Company. Additionally, notice of meetings will be sent to You or Your proxy upon written request for such notice directed to Our secretary.

V. If the Law Requires, We Will Extend Time Limits

If any limitation for giving notice of Claim or bringing any action on this Plan is less than that allowed by the laws in the state, district, or territory where You live when We issue this Plan, We will extend the limitation to comply with the law.

W. You May Have Two Contracts with Blue Cross and Blue Shield

You may have this Contract plus another individual or group Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. policy, as long as the other policy is not a limited Benefit Cancer and Serious Disease Contract.

X. This Contract Is Between You and Blue Cross and Blue Shield of Louisiana

Subscribers expressly acknowledge that they understand that this Plan is a Contract solely between them and Blue Cross and Blue Shield of Louisiana (the *Company*). We are 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*). The Association permits Us to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana; We are not contracting as the Association's agent. You also acknowledge and agree that You have not entered into this Contract based on representations by anyone other than Us. No person, entity, or organization other than Us will be held accountable or liable to You for any of Our obligations under this Plan. This paragraph will not create any additional obligations for Us other than those created under other provisions of this Contract.

Y. Out-of-Area Services

Blue Cross and Blue Shield of Louisiana has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever You obtain healthcare services outside the geographic area We serve, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of Our service area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits when paid as medical Benefits, and those Prescription Drug Benefits or vision care Benefits that may be administered by a third party contracted by Us to provide the specific service or services.

1. BlueCard® Program

   Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

   When You receive Covered Services outside Our service area and the Claim is processed through the BlueCard® Program, the amount You pay for the Covered Services is calculated based on one of the following, as determined by Us:

   - the billed charges for Your Covered Services;
   - the negotiated price that the Host Blue makes available to Us; or
   - an amount determined by applicable law.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into

account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of Claims, as noted above. However, such adjustments will not affect the price We have used for Your Claim because they will not be applied after a Claim has already been paid.

2. Special Case: Value-Based Programs

   a. BlueCard® Program

      If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments.

   b. Negotiated (non-BlueCard® Program) Arrangements

      If We have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Our Members, We will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

   Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, We will include any such surcharge, tax or other fee as part of the Claim charge passed on to You.

4. Non-Participating Providers Outside Our Service Area

   a. Member Liability Calculation

      When Covered Services are provided outside of Our service area by Non-Participating Providers, the amount You pay for such services will normally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, may govern payments for out-of-network Emergency Medical Services.

   b. Exceptions

      In certain situations, We may use other payment methods, such as billed charges for Covered Services, the payment We would make if the healthcare services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

5. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard® service area"), You may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists You with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard® service area, You will typically have to pay the Providers and submit the Claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact Us to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Contract.

b. Outpatient Services

Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require You to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global® Core Claim

When You pay for Covered Services outside the BlueCard® service area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of Your Claim. The claim form is available from Us, the Blue Cross Blue Shield Global® Core service center, or online at **www.bcbsglobalcore.com**. If You need assistance with Your Claim submission, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Z. This Contract Is in Addition to Medicare

For this Plan, We will not reduce Covered Benefits by any amounts that Medicare paid or may pay. This Plan pays in addition to Medicare.

AA. Our Right to Offer Premium Incentives

We may, at Our discretion, offer rebates, refunds, reductions of premium, or other items of value, in amounts or types determined by Us, for business purposes and healthcare quality and improvement purposes, including but not limited to the following purposes:

1. Encouraging Members to participate in quality programs;
2. Ensuring Members are better able to afford benefits packages;
3. Reducing and alleviating social determinants of health;
4. Reducing transition costs for Members who have changed insurers;
5. Rewarding Members for choosing lower cost, quality healthcare providers;
6. Rewarding Members for selecting lower cost, quality healthcare goods and products;
7. Rewarding Members for utilizing digital and other paperless forms of communication of information, including but not limited to plan documents and materials; and
8. Reducing enrollment, technology, or administration costs of Members, when such costs are related to effectuating and/or maintaining coverage.

Article 11. How Can You File a Complaint, Grievance, or Appeal?

At some point when You have this Plan, You may want to complain about a service, file a Grievance with Us, or Appeal a decision We made. Read this section to learn about the different procedures to follow for each problem.

- When You call to tell Us that You are dissatisfied with a service, that is called a *Complaint*.
- When You write to Us that You are dissatisfied with a service, that is a *Grievance*.
- When You or Your authorized representative formally asks Us to change a decision that We made about Your Benefits, that is an *Appeal*.

A. What Should You Do When You Have a Complaint or Grievance?

Sometimes Members are unhappy with Our services, access, availability, or attitude.

- **If You want to complain to Us**, call Us. We will try to solve Your problem when You call:

Customer Service Department
1-800-599-2583 or 1-225-291-5370

- If You feel that We did not resolve Your Complaint on the phone or **if You wish to file a formal Grievance**, You must write to Us. Our Customer Service Department will help You file a Grievance, if You need help.

  Send Your Grievance letter to Us at:

Blue Cross and Blue Shield of Louisiana
Appeals/Grievances Department
P. O. Box 98045
Baton Rouge, LA 70898-9045

We will mail You a response within 30 business days after We receive Your Grievance.

B. What Should You Do When You Want to Appeal a Decision?

If You want to ask Us to change a decision that We made, You may file an Appeal. For example, You may Appeal Our decision if We denied a Claim based on Plan limitations or exclusions. When You file an Appeal, send Us all of the information You have so that We can completely evaluate Your situation. We try to respond quickly, review any documentation in a timely manner, and resolve disputes effectively.

The Appeals process has two levels, including a committee review at the second level.

Send Us only one request for an issue. We will not consider multiple requests to Appeal the same Claim, service, issue, or date of service at any level of review.

You can appoint someone to represent You.

If You prefer, You can have someone else act for You. We call that person an *authorized representative*. If You want to name Your Physician or someone else as an authorized representative, You must write to Us that You want someone to work with Us for an Appeal of denied Benefits.

We will notify Your providers of the Appeal results only if they filed the Appeal for You.

1. **First-Level Appeal**

   If You are dissatisfied that We denied Benefits, You can ask Us to review Your case. You or Your authorized representative must first write to Us within 180 days after We denied Benefits. If We receive Your request after 180 days, We will not consider it.

   Write to:

   Blue Cross and Blue Shield of Louisiana
   Appeals/Grievances Department
   P. O. Box 98045
   Baton Rouge, LA 70898-9045

   If You have questions or need help writing the Appeal, call:

   Customer Service Department
   1-800-599-2583 or 1-225-291-5370

   When We receive Your request for a first-level Appeal, We will investigate Your concerns.

   Within 30 working days after We receive Your request for a first-level Appeal, We will write to You, unless You, Your authorized representative, and We agree that We have more time to respond.

   - If We change Our original decision at this level, We will process Your Claim and will write to You and all appropriate providers.

   - If We do not change Our original decision, We will write to You and all appropriate providers to explain that You can ask for a second-level Appeal.

2. **You Can Then Ask for a Second-Level Appeal**

   If You are still dissatisfied with Our decision, You can ask Us for a second-level Appeal. You or Your authorized representative must write to Us within 60 calendar days after Our decision for the first-level Appeal. If We receive Your request after 60 days, We will not consider it.

Write to:

Blue Cross and Blue Shield of Louisiana
Appeals/Grievances Department
P. O. Box 98045
Baton Rouge, LA 70898-9045

If You have questions or need help writing the Appeal, call:

Customer Service Department
1-800-599-2583 or 1-225-291-5370

A Member Appeals Committee whose members were not involved in Your case before will meet to review Your request. The meeting is normally held within 45 working days after We receive a request for a second-level Appeal. Once the Committee decides on Your case, it will mail its decision to You within 5 working days after the meeting. The Committee's decision is final and binding.

Article 12. Other Things You Should Know

We continue to update Our online access for Members. You may now be able to go online for many functions described below, without contacting Our Customer Service Unit. Simply log on to **www.bcbsla.com**.

For copies of the forms mentioned in this Plan:

- Download them from the *Forms for Members* page at **www.bcbsla.com**,
- Contact one of Our local service offices (Blue Cross and Blue Shield of Louisiana has Local Service Offices in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Monroe and Shreveport) or
- Write to Us at:

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

- The *Individual Change of Status Card* has the medical questionnaire on the reverse side. Go online at **www.bcbsla.com** or see Your insurance agent for a copy.

- Mail documentation for a Claim to Us at:

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

or:

Blue Cross and Blue Shield of Louisiana
5525 Reitz Avenue
Baton Rouge, LA 70809

or fax it to the Blue Cross Claims Department at:

(225) 295-2147

- If You have questions about any information in this section, call Your insurance agent or call Us at:

Customer Service Department
1-800-599-2583 or 1-225-291-5370

Your ID Card Helps When You Travel

Your *Blue Cross and Blue Shield Identification Card* (ID card) allows shows You to conveniently receive healthcare when You travel outside of Louisiana. If You travel or live outside of Louisiana and You need medical attention for Covered Disease, follow these steps:

1. In an Emergency, go directly to the nearest Hospital.
2. For information about the nearest Physicians and Hospitals, call BlueCard® Access:

   1-800-810-BLUE or 1-800-810-2583
3. To receive the highest level of Benefits, go to a designated Provider.
4. When You go to a Physician or Hospital, show Your ID card so they can verify Your coverage and file Claims for You.

How to Change Which Family Members Are on Your Plan

See the *Schedule of Eligibility* to learn how to add family members to Your Plan. If You have any changes in Your family, You must fill out the *Individual Change of Status Card* and the medical questionnaire portion for Your family members. If You do not fill out and return the *Change of Status Card* within the timeframes stated in the *Schedule of Eligibility*, You may not be able to add family members to Your Plan. Completing that *Change of Status Card* is especially important when Your first Dependent becomes eligible for coverage or when You no longer have Dependents who are eligible for this Plan.

- Generally, use an *Individual Change of Status Card* to add newborn children and newborn adopted children to Your Plan. Send it to Our home office within 30 days after the child's birth or placement in Your home. You do not have to fill out the medical questionnaire portion.
- You must fill out the medical questionnaire portion to add a new spouse or other Dependents who were not listed on Your original *Application for Individual Coverage*. If We accept Your Dependents for coverage, We will assign them the next available Effective Date.
- If You marry and wish to add Your new spouse to Your Plan, file the *Individual Change of Status Card.* Have Your spouse fill out the medical questionnaire portion. If We accept Your spouse for coverage, We will assign Your spouse the next available Effective Date.

How to Claim Your Benefits

If You file Your Claim Yourself, We will pay You directly. If Your Provider files the Claim for You, We will pay the Provider. Typically, participating providers will file Claims for You either by mail or electronically. Separate Claims must be filed under this Plan and any other health plan You have. Sometimes Providers may ask You to file the Claim Yourself. If a Provider asks You to file directly with Us, use the following information to correctly fill out the Claim form.

Check Your Identification Card for the Correct Way to Write Your Name

Your *Blue Cross and Blue Shield Identification Card* (ID card) shows how the Subscriber's name appears in Our records. If You have Dependent coverage, Your names are recorded as it was written on the application.

The ID card also shows Your Contract number. This number identifies Your membership records for Us. Use it each time You file a Claim.

Fill in the Proper Details

To help in promptly handling Your Claims, be sure that:

1. You use an appropriate Claim form.
2. The Contract number (ID #) on the form is the same as the number on Your ID card.

3. You fill in the patient's date of birth.
4. You properly state the patient's relationship to the Subscriber. If the Subscriber is the patient, the relationship is *self*. If Your spouse is the patient, the relationship is *spouse*.
5. You itemize all charges, either on the Claim form or on the attached statement.
6. The date of service (*date of Inpatient Admission to a Hospital or other provider*) or date of treatment is correct.
7. You include a diagnosis code and a procedure code for each service or treatment received (the diagnosis code pointers must be consistent with the Claim form).
8. You complete the form and sign it.
9. Check all Claims to make sure that they are accurate and the Contract number (ID #) is correct. **Keep a copy of all bills and Claims You submit.**
10. Mail Your paper Claim form to:

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

11. Or fax it to the Blue Cross Claims Department at:

(225) 295-2147

Other Information About Filing Specific Claims

Claims if You Are Admitted to a Hospital or Allied Health Facility

When You are being admitted to a facility, show *Blue Cross and Blue Shield Identification Card* (ID card) to the admitting clerk. Your Provider will file the Claim with Us.

Usually, We will pay the facility directly. Your Provider will then bill You directly for any remaining balance. After We have processed the Claim, You will receive an *Explanation of Benefits* that shows You all the details of the services and treatments You received.

Claims if You Go to an Emergency Room or Outpatient Department

The procedure to be followed is the same as that for an Admission.

However, in some instances involving emergencies or Outpatient treatment, Providers may ask You to pay directly. If this occurs, get an itemized copy of the bill, be sure the Claim form is complete and correctly notes the following information:

- The Contract number (ID #) on the form must be the same as the number on Your ID card.
- The patient's full name.
- The patient's date of birth.
- The patient's relationship to the Subscriber.
- Dates of service
- Name and address of Provider of service.
- Diagnosis code
- Description of and procedure code for service
- The itemized charges for each procedure or service. **Note**: Statements, canceled checks, payment receipts and balance forward bills do not replace itemized bills.
- The Provider must mark the statement or Claim form *PAID*.

Send completed Claim form to:

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

Prescription Drug Claims

If You have Prescription Drug coverage, You pay for the drugs when You buy them and then You must file Claims to receive Benefits. To file, You must use the *Prescription Drug Claim Form* and have Your pharmacist sign it (or an attachment that We accept). After the form is completed, send it to Us at:

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

Other Medical Claims

When You receive other medical services (For instance, when You go to clinics or Provider offices), ask if the Provider has contracted with Blue Cross and Blue Shield of Louisiana. If so, this Provider will file Your Claim with Us. When Your Provider files on Your behalf, We will pay Your Provider based on Our contracted terms.

However, in some instances, Providers may ask You to pay directly. If this occurs, get an itemized copy of the bill, be sure the Claim form is complete and correctly notes the following information:

- The Contract number (ID #) on the form must be the same as the number on Your ID card.
- The patient's full name.
- The patient's date of birth.
- The patient's relationship to the Subscriber.
- Dates of service
- Name and address of Provider of service.
- Diagnosis code
- Description of and procedure code for service
- The itemized charges for each procedure or service. **Note**: Statements, canceled checks, payment receipts and balance forward bills do not replace itemized bills.
- The Provider must mark the statement or Claim form *PAID*.

Send completed Claim form to:

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

Claims for Nursing Services

If You receive nursing services, You must have a receipt from each nurse that shows the patient's name and the number of days covered by each receipt.

The nurse must sign each receipt, write the initials *RN* or *LPN*, and write a registry number.

You must also file a statement from the attending Physician or Allied Health Provider with the receipts for nursing services.

Claims for Durable Medical Equipment (DME)

If You rent or buy wheelchairs, braces, crutches, etc., charges must be on the bill of the supplying firm, giving a description of the item, the date, the charge, and the patient's name.

You must also file a statement from the attending Physician or Allied Health Provider with these bills.

If You Have Questions About Your Claim

If You have questions about the processing or payment of a Claim,

- Write to Us at:

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

- Call any of Our local service offices (Blue Cross and Blue Shield of Louisiana has Local Service Offices in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Monroe and Shreveport), or
- Call Our home office at:

Customer Service Department
1-800-599-2583 or 1-225-291-5370

If You call for information about a Claim, have the Contract number, patient's name, and date of service handy so We can better help You.

Remember, ALWAYS refer to Your Contract number in all correspondence and recheck Your number against the one on Your ID Card to be sure it is correct.

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, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@lablue.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries 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 Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.**

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. **If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at **www.lablue.com**.

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana Inc. and Southern National Life Insurance Company Inc., are independent licensees of the Blue Cross Blue Shield Association.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)