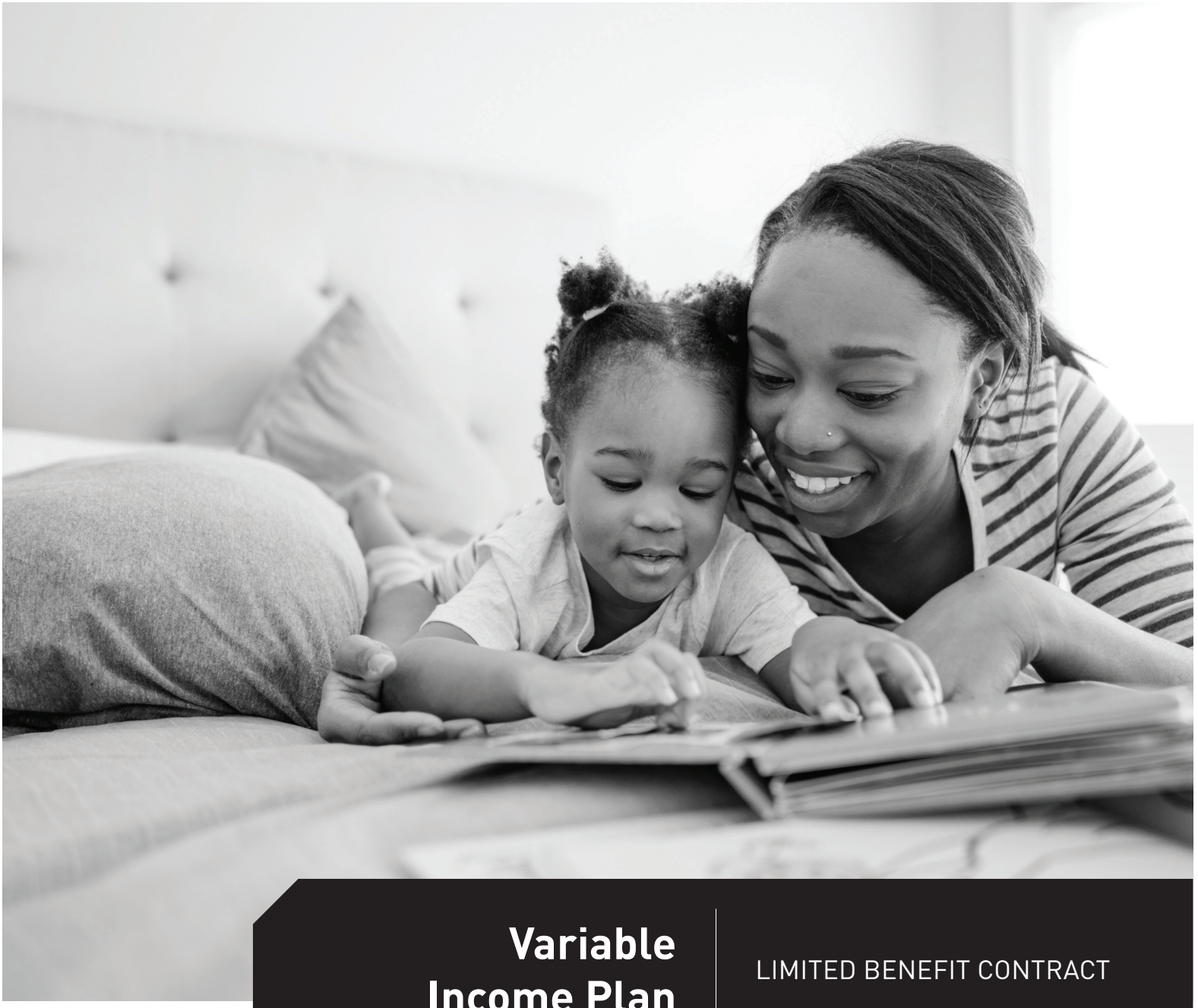

Variable Income Plan

LIMITED BENEFIT CONTRACT

Louisiana

40XX1172 R01/24

Louisiana

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS POLICY DOES NOT SATISFY THE REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. LACK OF MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS IS A LIMITED BENEFIT POLICY. READ CAREFULLY.

Your Variable Income Plan

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.

This *Variable Income Plan* has limited Benefits. Read it carefully to make sure that You understand what this Plan offers You.

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.

I. Steven Udvarhelyi, M. D.
President and Chief Executive Officer
Louisiana Health Service & Indemnity Company

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.

40XX1172 R01/24

What's in this Contract?

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?* Read Your Plan carefully.

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 to the feminine gender, unless We state otherwise.

How Your Plan Works

This is a **variable income plan**. That means We will pay You cash to help cover expenses that You have when You are in the Hospital for a covered stay. You may choose how to spend the money. For instance, You could pay for anything from copayments to laundry, travel and lodging for family members, or even pet sitters or lawn mowing.

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.

We offer several types of variable income plans. When You bought this Plan, You chose a set amount of cash to receive for every day that You are in the Hospital. The chart below shows an illustration of the different types of variable income plans We offer, the Benefit amount options available, and whether payments would begin on the first day or third day of a covered stay.

Different Variable Income Plans at a Glance

What Variable Income Plans do We offer?	How much can You receive every day?	When will We begin to pay You?
1 **Preferred Plan**	$250 $200 $100	1st day of Your covered stay
2 **Budget Plan**	$250 $200 $100	3rd day of Your covered stay

To receive cash for Your expenses, You must file Your Claim with Us. You can choose how You want Us to pay:

- **If You file Your Claim Yourself,** We will pay the cash directly to You.
- **If Your provider files the Claim**, We will pay Your provider.

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 weight-control programs, vision and hearing care, and more.

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

Accidental Injury – A condition that directly results from a traumatic bodily injury sustained only through accidental means from an external force. Injuries caused by chewing are not accidental injuries to teeth.

Admission – The period for Inpatient care from entry (*admission*) into a Hospital until discharge. We do not count observation hours that are billed when a Hospital does not formally admit a patient as part of a covered Admission.

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

Benefits – Amounts We pay for a covered Admission under this Plan.

Claim – Written or electronic proof — in a form We accept — of a Member's covered Admission when the Member is insured under this Plan. The provisions that are in effect during the Admission govern how We process any Claim that a Member actually incurs as a result of an Admission.

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 a service.

Contract – This agreement, including the *Application for Individual Coverage,* 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.

Cosmetic Admission – An Admission that includes cosmetic surgery and plastic or reconstructive surgery, and any Admission that involves complications from that surgery and associated conditions. Also, any Admission that includes surgery which can be expected primarily to improve or restore physical appearance or which is performed for psychological purposes or which restores or corrects form, but does not correct or materially improve a significantly altered body function. Some examples of Cosmetic Admissions which are not covered are those for: rhinoplasty, mammoplasty (augmentation or reduction), and penile prosthesis. An operative procedure, treatment, or service is not a Cosmetic Admission if it restores bodily function or corrects deformity of a part of the body that an Accidental Injury, disease or disorder, or covered surgery has altered.

Custodial Admission – An Admission which does not involve treating an illness or injury or which is for the convenience of a Member or a Member's family. Also,

- An Admission primarily to provide room and board (with or without routine nursing care), training in personal hygiene and other forms of self-care and supervisory care by a doctor for anyone who is mentally or physically disabled and who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside a

Hospital providing medical care, or when, despite such treatment, no reasonable likelihood exists that the disability will be reduced; or

- Any Admission to any type of institution other than a Hospital; or
- Any Admission to any nursing home, convalescent home, skilled nursing or extended care unit or facility, or holistic health retreat.

Day – A 24-hour period that begins at 12:01 A.M. If the first and last Days of an Admission occur on the same day, We count it as 1 Day for Benefit payment.

Dental Care and Treatment Admission – An Admission to a Hospital where a Member received any procedure, treatment, or 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*.

Effective Date – The date coverage begins under this Plan.

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

Hospital – An institution that the appropriate state agency licenses as a general medical surgical Hospital. *Hospital* does NOT include, other than incidentally, a unit or facility for psychiatric, chemical dependency, rehabilitation, skilled nursing, extended care, long-term care, or intermediate care.

Inpatient – A Member who is admitted to the Hospital as a registered bed patient, for whom a bed, board, and general nursing services are rendered. An Inpatient's medical symptoms or condition must require a doctor 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 for an Inpatient.

Maternity Complications Admission – An Admission of the Subscriber or the Subscriber's spouse for care other than a normal vaginal delivery or a cesarean section when the mother's life is threatened or the viability of the fetus is threatened. To be eligible for Benefits for Maternity Complications, the Subscriber and Subscriber's spouse must both be covered under this Plan.

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.

Observation – Entry into a Hospital that does not result in an Inpatient Admission and the Hospital does not bill that period as an Inpatient Admission. Observation status may be as long as 30 hours.

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.

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.

Pre-Existing Condition Admission

- A condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care, or treatment during the 365 days immediately before the Effective Date of this Contract; or
- A condition for which medical advice, diagnosis, care, treatment, or a prescribed drug was recommended or received during the 365 days immediately before the Effective Date; or
- A pregnancy existing on the Effective Date.

We do not treat genetic information as a Pre-Existing Condition if no diagnosis of the condition related to that information existed.

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.

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.

Substance Use Disorders Admission – An Admission to a Hospital or a chemical dependency unit to treat chemical dependency, alcoholism, or drug addiction.

Variable Income Plan – The daily Benefit plan for which a Member is eligible to apply and has applied, for which We have accepted an application, and for which current premiums have been paid.

Article 3. Schedule of Eligibility

By amendment, We may delete or revise any eligibility requirement in this Plan that is not mandated by state or federal law.

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?

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, subject to any waiting period We explain later in this Plan.

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

    a. If You have a *Subscriber Only* or *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. Then Your child could be subject to an exclusion period for Pre-Existing Conditions.

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.

9. **How to add Dependent Children who lose their coverage under the Louisiana Children's Health Insurance Program or a Medicaid Program**

If Your Dependent child is enrolled in the State Children's Health Insurance Program or a Medicaid Program, and Your child loses that coverage, You may add the child to this Plan. To do so, fill out and send Us the *Individual Change of Status Card* within 30 days after Your child loses the other coverage. If We receive the completed card within 30 days, the child's coverage under this Plan will become effective on the date Your child lost the original coverage. We may adjust Your premiums when You add Your child to this Plan.

Article 4. What Benefits May You Receive in this Plan?

By amendment, We may delete or revise any Benefit requirement in this Plan that is not mandated by state or federal law.

If You go into a Hospital for a covered Admission, this Plan will pay according to the *Variable Income Plan* that is in effect when the stay begins. Your identification card shows You which *Variable Income Plan* You have.

Your Plan limits how much it will pay over Your lifetime

In total, this Plan will pay You for up to 365 Days of Inpatient Hospital care over the course of Your lifetime. Of those 365 Days, the Plan will pay for up to 30 Days for treatment for mental or emotional disorders.

Article 5. How Are Benefits Paid?

How Are Benefits Paid?					
Plans		**How much can You receive every day?**			**When will We begin to pay You?**
1	**Preferred Plan**	$250	$200	$100	1st day of Your covered stay
2	**Budget Plan**	$250	$200	$100	3rd day of Your covered stay

1. **Preferred Plan**: Options of $250, $200, and $100 a Day are available. Payments begin the 1st day of a Member's Inpatient covered Admission.

2. **Budget Plan:** Options of $250, $200, and $100 a Day are available. Payments begin on the 3rd day of a Member's Inpatient covered Admission.

   Any rights or Benefits that a Member has under this Plan belong to that Member only; You cannot give them to anyone else.

   When You file Your Claim with Us, We will pay You directly. If Your provider files Your Claim for You, We will pay Your provider directly.

Article 6. When Won't the Plan Pay? Limitations and Exclusions

By amendment, We may delete or revise any Limitations and Exclusions requirement in this Plan that is not mandated by state or federal law.

Important: See *Article 2. What Terms Do We Use in this Plan?* to help as You read this article.

This Plan will NOT pay Benefits for any of the following:

1. Admissions for Pre-Existing Conditions, if within 365 days after Your Effective Date. A diagnosis is not necessary for a condition to be considered a Pre-Existing Condition.

2. Admissions for obstetrical care, except for Maternity Complications.

3. Admissions for Maternity Complications for treating Members with classes of coverage for either *Subscriber Only* or *Subscriber and Children*. Admissions for Maternity Complications for treating Members who are enrolled as minor Dependents.

4. Custodial Admissions.

5. Substance Use Disorders Admissions.

6. Cosmetic Admissions.

7. Admissions for Dental Care and Treatment and dental appliances.

8. Diagnosis, treatment, or surgery of dentofacial anomalies including malocclusion, Temporomandibular/Craniomandibular Joint Disorder, hyperplasia or hypoplasia of the mandible or maxilla, and any orthognathic condition.

9. Any Admissions after the Plan ends, regardless of the cause of termination (except as provided under *Article 7*), and for an Admission that was in progress on the date Your Plan becomes effective.

10. Admissions outside of the United States.

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

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

13. Admissions occurring as a result of taking part in a riot or acts of civil disobedience.

14. Admissions 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). You may receive Benefits for illness or bodily injury due to 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 condition.

15. Admissions which are not Medically Necessary.
16. Admissions if You are confined to a prison, jail, or other penal institution.
17. Observation hours billed when a Hospital does not formally admit You as a patient.

Article 7. 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; *Your Variable Income Plan* document; 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 Admissions beginning on and after Your Effective Date into a Hospital defined in this Plan for Inpatient care.

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 doctor, 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 when admitted to a Hospital for Inpatient care. 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, doctors, 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.

4. **We will base Your premiums on the Subscriber's age.** Premiums can change when You reach age 35, 50, and 65 if We write to You 45 days before they change.

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 Contact. 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 Plan 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 Inpatient Days 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. 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 *b.* 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 Admissions 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, as defined under *Article 1*, the *Variable Income Plan* will stop when the Admission ends or when the lifetime maximum of 365 Days has been met, 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 31 days after this Plan ends that they want to continue it. If We receive their notice within 31 days of the Plan's end, their coverage will continue and they will not have to prove that they are insurable.

8. We can automatically change the class of coverage to reflect the membership in the Plan.

9. 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 You are admitted to a Hospital, 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 the date you were admitted to a Hospital.

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 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. 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.

P. We Have the Right of Recovery

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

Q. 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.

R. 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.

S. 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 8. How Can You File a Complaint, Grievance, or Appeal?

At some point when You have this Plan, You may want to complain about 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 doctor 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.

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

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 9. Which Forms Do You Need for This Plan?

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

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

Or fax it to the Blue Cross Claims Department at:

(225)295-2147

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.

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.

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

Nondiscrimination Notice

Discrimination is Against the Law

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

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

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

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

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

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

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

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

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

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

Or

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

NOTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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