01MK5306 R04/24

Welcome to Blue Cross

Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc., are committed to the health of our customers. We are proud to serve our fellow Louisianians and look forward to a long and healthy relationship.

Important Information
Please read this important information about your policy and keep it for your records. Inside, you'll find information about your insurance benefits, answers to frequently asked questions and a glossary of important insurance terms.

Customer Service
If you ever have questions about your policy, try our convenient, secure online inquiry form on the web at **www.bcbsla.com**. Just click on **Contact Us** at the bottom of the page to send us a message securely, day or night. You can also call Customer Service toll-free at the number on the back of your ID card, Monday through Friday from 8 a.m. to 8 p.m.

Once again, we are proud to welcome you to our member family. Thank you for allowing us the opportunity to serve you.

Sincerely,

Michael M. Carriere II
Vice President, Benefit Operations – Enrollment and Billing

01MK3861 R09/22

Table of Contents

Thank You for Choosing Blue

Since 1934, Blue Cross and Blue Shield of Louisiana has proudly served the healthcare needs of Louisianians. We are committed to providing health guidance and affordable access to quality care so you'll know more and live well. This brochure provides information that will help you get the most value from your new insurance policy.

What Blue Cross Offers

- Large provider networks
- Local presence
- Local customer service
- Technology for your convenience and information
- ID card recognized by most doctors around the globe
- Strength and stability

How Blue Cross Works for You

Your Policy

Because we offer several different policies, it's a good idea to know what your specific plan covers.

These details are in your insurance policy (also known as your *benefit plan*) and your *Schedule of Benefits*. The Schedule of Benefits is inserted in the front of your contract and is a summary of the services and procedures for which you will receive coverage, as well as any copayments, deductibles or coinsurance associated with them. If you still have questions regarding coverage, please call Customer Service at the number on the back of your ID card or email us at **help@bcbsla.com**.

Strong Provider Networks

Our home state location means we deal directly with local providers and negotiate contracts face-to-face. Our more than 1.9 million customers give us the power to negotiate strong provider discounts. Find a provider near you by visiting our online provider directory, which is updated daily and lists the thousands of doctors and hospitals who participate in our networks. Use our online directory by going to **www.bcbsla.com** and clicking Find a Doctor or Drug on the home page. You can also call Customer Service, and a courteous representative will either help you find a provider or mail you a copy of our provider directory.

Customer Service

Our team of experienced and knowledgeable customer service representatives – all located in Louisiana – can answer a wide range of questions. You may find some answers to your questions on our website at **www.bcbsla.com**. You can also email us at **help@bcbsla.com** or call the number on the back of your ID card. And if you're interested in policy options, we have multiple district sales offices around the state. They specialize in face-to-face service.

Frequently Asked Questions

1. What documents do I need to make the best use of my coverage?

ID card – This personalized card has your unique benefit plan number on it. Please carry it with you. Providers will want to see it before they serve you. It may be mailed to you separately from your benefit plan.

Insurance Policy – This is your benefit plan. It spells out the benefits and coverage provisions of your policy. It includes what is covered and what is not, and any dollar limits. Your Application for Coverage and your Schedule of Benefits are part of your insurance policy. Your benefit plan is replaced annually.

Schedule of Benefits (SOB) – This is a summary of the services and procedures for which you will receive coverage, as well as any copayments, deductibles and coinsurance associated with them. Your Schedule of Benefits is replaced annually.

Summary of Benefits and Coverage (SBC) – Provides standard benefit information to help you understand your health coverage.

2. How do I know if something is covered?

The first place you should look is in your insurance policy. This benefit plan is divided into categories of coverage. It also includes a list of services that are excluded from coverage. Your Schedule of Benefits, which is inserted in the front of your benefit plan, is a summary of your financial obligations for services including copayments, deductibles and coinsurance. Your benefit plan and Schedule of Benefits together provide the specific details of your coverage. If you still have questions regarding coverage, please call or email Customer Service. The number is located on the back of your ID card.

3. How do I find a doctor in my network?

Access our online provider directory at **www.bcbsla.com** for the most current listing. Click on Find a Doctor or Drug on the home page and it will take you to the online directories. You can also call Customer Service, and a courteous representative will either help you find a provider or mail you a copy of our provider directory.

4. How do I find out if I have prescription coverage and, if so, how much my prescription will cost?

First, please check your Schedule of Benefits to see what type of prescription drug coverage you have, if any.

Blue Cross offers several ways to help you get the most out of your prescription drug coverage. You can download a prescription drug list (also known as a *formulary*) at **www.bcbsla.com/CoveredDrugs**.

Your personal prescription drug information is also available online through Express Scripts* at **www.express-scripts.com**. Here you will find out-of-pocket cost information, a pharmacy locator and more.

**Express Scripts is an independent company that provides pharmacy management services to Blue Cross and Blue Shield of Louisiana.*

5. Where do I check to see if something should be pre-authorized?

Inpatient hospital stays and certain other services require authorization before you receive the services. Your Schedule of Benefits includes a summary list of these services or procedures that require prior authorization. You can view a list of items and services that require prior authorization by visiting **www.bcbsla.com/priorauth**. If you have any questions, our customer service representatives will be glad to answer them.

6. How do I file a claim?

If you receive services from a network provider, your claims will be filed automatically for you. You do not need to submit a claim. In a case where you do need to file a claim, forms are available in the Forms and Tools section, which is at the bottom of every page on our website.

7. What if I lose my ID card, contract or Schedule of Benefits? How do I get new copies?

If you lose any of these items, you can call or email Customer Service to order new ones. You can also order a new ID card and view your digital medical ID card through your online account.

8. What if I don't agree with a decision made by Blue Cross or HMO Louisiana, Inc.?

We want to know when you are unhappy about the care or services you receive from us or from one of our network providers. That's why we have a formal process for customers to appeal any of our decisions or state any grievances. To learn more about these processes, please visit **www.bcbsla.com**, call Customer Service at the number on the back of your ID card, or refer to the Complaint, Grievance and Appeal Procedure section of your contract.

How Blue Cross Will Contact You

During our business relationship, you can expect us to contact you in several ways. Most communications will come through regular mail, and in some cases email.

Some exceptions include:

- Telephone surveys
- Telephone reminders of recommended wellness visits or immunizations
- Calls to customers who are eligible for special services, such as help managing a disease or difficult condition
- Returning your call

Mail may include:

- Newsletters
- Your premium payment notice
- Notices we must send to comply with state or federal insurance guidelines
- Explanation of Benefits (EOB)
- Letters
- Questionnaires and surveys
- Forms requesting information

Please note that all written communications will show the Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc., logo. If the logo appears to be crooked or distorted, it may not be an authentic communication from us.

- If at any time you are suspicious or concerned that a communication you receive may not really be from Blue Cross, please contact us immediately.
- You may report suspicious activity to our Fraud Hotline at 1-800-392-9249.

Definitions*

- **Allowable Charge** — the lesser of either (1) the billed charge from the provider; or (2) the amount we establish or negotiate as the maximum amount allowed for all provider services covered under the terms of your Benefit Plan.
- **Benefits** — the healthcare services and supplies the insurer agrees to pay for under the terms of your insurance policy.
- **Claim** — a request by an insured person (or a provider) for the insurance company to pay for healthcare services.
- **Coinsurance** — some insurance policies require the customer to pay a percentage of the healthcare bill. This usually happens after the deductible has been satisfied. With coinsurance, the customer pays a percentage, and the insurance company pays the rest, up to the company's allowable charge for the service.

- **Copayment** — a fixed dollar amount that a customer pays for a covered service or prescription drug.
- **Deductible** — the amount a customer must pay for covered healthcare services before insurance benefits kick in.
- **Dependents** — the spouse and/or unmarried children (whether natural, adopted or step) of an insured person, or other eligible people as listed in your Schedule of Benefits.
- **Drug formulary (or just formulary)** — a list of prescription drugs approved for use that may be covered.
- **Explanation of Benefits (EOB)** — the insurance company's written response to a claim, showing what the company paid and what the customer must pay.
- **Health Savings Account (HSA)** — a specific type of savings account that allows individuals to set aside funds tax-free to pay for select medical expenses. HSAs are available to people enrolled in qualified high-deductible health plans, like our Blue*Saver*® and Blue Connect Savings Plus, and many tax guidelines apply.
- **Health Reimbursement Arrangement (HRA)** — an employer-sponsored account to reimburse a portion of a participant's eligible out-of-pocket medical expenses, such as deductibles, co-insurance, and pharmacy expenses. An HRA is a reimbursement program funded entirely by an employer to help make healthcare more affordable.
- **HIPAA** — Health Insurance Portability and Accountability Act of 1996. A federal law that allows people to qualify immediately for comparable health insurance coverage when they change jobs or relationships. It also specifies requirements to protect the security and privacy of personally identifiable health information.
- **Patient Protection and Affordable Care Act** — passed in 2010, was designed to expand access to affordable health insurance to more people, especially people of modest income.
- **Pre-authorization** — a requirement that you or your provider contact the insurance company before certain healthcare services are received. Your Schedule of Benefits will tell you which healthcare services need to be pre-authorized.
- **Provider** — a term used for health professionals who provide healthcare services, including doctors and specialists, hospitals, urgent care clinics, allied health facilities and allied health professionals. A **participating provider** is part of an insurance company's network of providers that agree to accept a discounted rate for their services. A **primary care provider** (PCP) is a provider who is responsible for coordinating an individual's overall healthcare needs.

**These are general descriptions of coverage and coverage terms and are not meant to replace any definitions in your insurance policy or Schedule of Benefits. In case of conflict, the language in your insurance policy or Schedule of Benefits prevails.*

Online Tools Give 24-Hour Support

If you have questions about your health or health insurance, you can get answers day or night on our website at **www.bcbsla.com**.

You'll find a wide range of useful web-based tools for managing your account and researching medical conditions.

On our site, you can:

- Find a doctor in your network
- Learn about your prescription drug programs
- Search for the right policy for you
- Find health and wellness tools
- Get exclusive wellness discounts through Blue365®
- Request materials like this brochure in a language other than English

Create an Online Account at www.bcbsla.com

Your online account gives you the tools you need to get the most out of your health plan. To register for an online account with Blue Cross, have your member ID number handy and visit **www.bcbsla.com/activate**.

Here are a few things you may do through your online account:

- Review your claims and your digital medical ID card.
- View your Explanation of Benefits (EOB) statements.
- Select/Change choice of doctor as your primary care provider (PCP), if applicable to coverage.
- Change the email address or password on your account.
- Get details on your health plan, like how much of your deductible has been met.
- Take your Health Assessment to learn about any health risks you may have and how to address them.
- Choose to go paperless, if possible.
- Access pharmacy tools through Express Scripts and Rx Savings Solutions, if applicable to coverage.
- Start a BlueCare online medical visit 24/7 or mental health visit by appointment using a computer, smartphone, tablet or any device with internet and a camera. Before every visit, you will see what it will cost based on your plan type and benefits. You will not be charged until the visit is complete. To enroll or login for a visit, download the free BlueCare app or go to **www.BlueCareLA.com**.

Care Management and Wellness Programs

We understand that our customers like a little lagniappe. That's why we offer bonus programs and services designed to help you live a healthier, happier life.

Care Management Services

Members become STRONGER THAN EVER with our Care Management programs working for them. We offer care management programs with health coaching, education and hands-on support to help members with chronic conditions or serious illnesses. With a team of clinical professionals, including doctors, nurses, dietitians, pharmacists and social health coaches, we share personalized information to encourage members on their journey to optimal health. If you have diabetes, heart disease, other chronic conditions, traumatic injuries or serious illnesses, these programs help guide you through the healthcare system and get the services you need in a timely manner. Members do not pay anything to work with a health coach. Visit **www.bcbsla.com/stronger** to learn more.

Best of all, these services are available to you at no additional cost.

Disease Management

1. **Have you been diagnosed with a chronic health condition?**

   If so, you could benefit from an assessment by one of our Disease Management nurses, also called Health Coaches, to see if Disease Management might be an option for you.

2. **How will a Health Coach benefit you?**
   - Personal, confidential support and attention
   - Preventive and wellness care reminders
   - Improved and up-to-date self-management techniques and support
   - Nurse coaching support in areas in which you want to make changes
   - Support for health decisions and conversations with caregivers and health providers

3. **How do I contact a Health Coach?**
   - Call 1-800-317-2299 and choose Option 1
   - Call 225-295-3307 extension 1068 and choose Option 1

   Together, you and your Health Coach will make plans to maintain or improve your condition and overall health.

Personalized Wellness Program

Good health begins at **www.bcbsla.com/wellness**. This program is included in all our insurance plans at no extra cost with features that include:

- A Health Assessment to help you learn more about your health. Our Health Assessment goes beyond the standard health risk questions to assess mindset, readiness to change and productivity.
- Interactive tools that let you track your weight, blood pressure and cholesterol and sync the data to popular health tracking tools.
- Fitness and nutrition plans that can be customized for you and your family.
- Comprehensive online learning modules that focus on topics such as preventive care, nutrition, smoking cessation, stress management and weight management.
- Secure and confidential user log-in and data collection.

Begin your personal journey of good health. Log into your online account and take your Health Assessment today.

Security and Confidentiality: The Health Assessment has been engineered to provide the same level of protection for your confidential health information that online banking and consumer websites offer their clients and account-holders. If you are identified as someone who may benefit from Care Management Services, your information may be shared with medical personnel, and you may be contacted by a Care Management nurse.

The information you provide in the Health Assessment will be used only as permitted by law. This information will not adversely affect your enrollment in your health plan.

Healthy Wellness Discounts from Blue365®

Healthy Living Made Simple. As a member of Blue Cross and Blue Shield of Louisiana you have access to exclusive health and wellness deals through Blue365, a free member discount program. With the help of Blue365, creating a healthy lifestyle is easy and affordable. You will enjoy discounts from your favorite national and local retailers on fitness gear, gym memberships, vision care, nutrition programs and more! Blue365 helps you stay healthy for less with exclusive discounts including:

- Discounted fitness memberships with access to thousands of nationwide gyms and virtual programs
- Wearable devices
- Athletic footwear
- Healthy eating discounts
- LASIK eye surgery, hearing aids and much more

Signing up is simple. Plus, you'll receive personalized deals and wellness tips straight to your inbox after you register so healthy savings are just a click away. Take charge of your health today and visit **www.Blue365Deals.com** to start saving.

Joining Blue365 and redeeming our deals is as easy as 1-2-3. Get started with your free registration at **Blue365Deals.com/register**.

1. **Click the Join or Check Eligibility Button**
   You'll find these at the middle and top right of the Blue365 home page at **www.Blue365Deals.com/BCBSLA**.

2. **Enter Your BCBS Member Information**
   To check your eligibility, simply enter the first three characters in your member number on your member ID card.

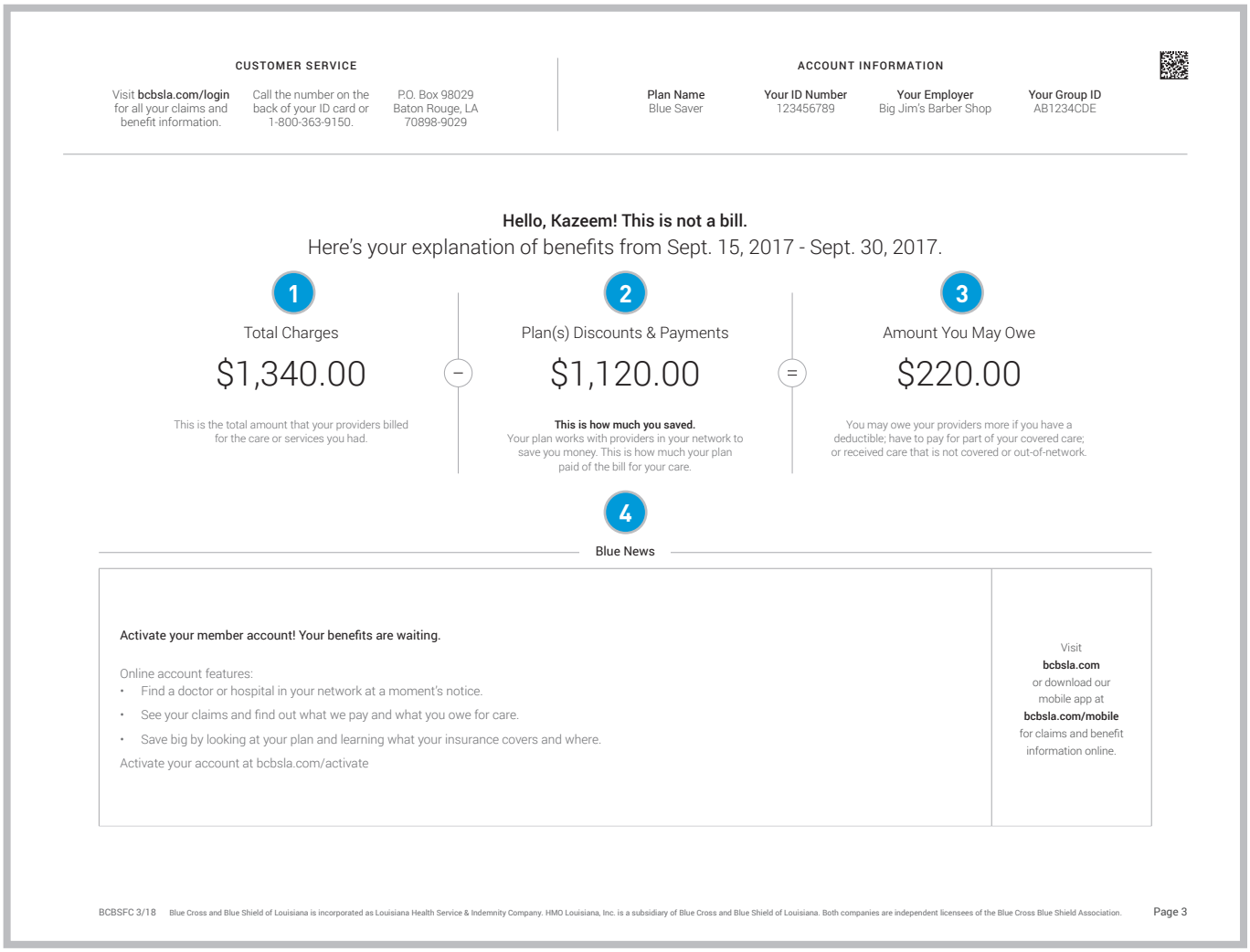
3. **Complete Your Registration**
   Enter your personal information, accept our Terms and you are ready to enjoy our deals!

You can also browse deals anytime on the Blue365 website. The Blue365 website is the most up-to-date source for current wellness offers and discounts. Explore all the healthy choices available anytime at **www.Blue365Deals.com/BCBSLA**.

How to Read Your **Explanation of Benefits** (EOB)

Welcome to your new Explanation of Benefits!

This document replaces the older format that you used to receive whenever you made a medical or dental visit, or when you purchased medications. It contains a summary page, followed by details of each of your visits and pharmacy purchases.



CUSTOMER SERVICE

Visit **bcbsla.com/login** for all your claims and benefit information.

Call the number on the back of your ID card or 1-800-363-9150.

P.O. Box 98029
Baton Rouge, LA
70898-9029

ACCOUNT INFORMATION

Plan Name	Your ID Number	Your Employer	Your Group ID
Blue Saver	123456789	Big Jim's Barber Shop	AB1234CDE

Hello, Kazeem! This is not a bill.

Here's your explanation of benefits from Sept. 15, 2017 - Sept. 30, 2017.

1 Total Charges

$1,340.00

This is the total amount that your providers billed for the care or services you had.

−

2 Plan(s) Discounts & Payments

$1,120.00

This is how much you saved.
Your plan works with providers in your network to save you money. This is how much your plan paid of the bill for your care.

=

3 Amount You May Owe

$220.00

You may owe your providers more if you have a deductible; have to pay for part of your covered care; or received care that is not covered or out-of-network.

4 Blue News

Activate your member account! Your benefits are waiting.

Online account features:

- Find a doctor or hospital in your network at a moment's notice.
- See your claims and find out what we pay and what you owe for care.
- Save big by looking at your plan and learning what your insurance covers and where.

Activate your account at bcbsla.com/activate

Visit **bcbsla.com** or download our mobile app at **bcbsla.com/mobile** for claims and benefit information online.

BCBSFC 3/18 Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross Blue Shield Association. Page 3

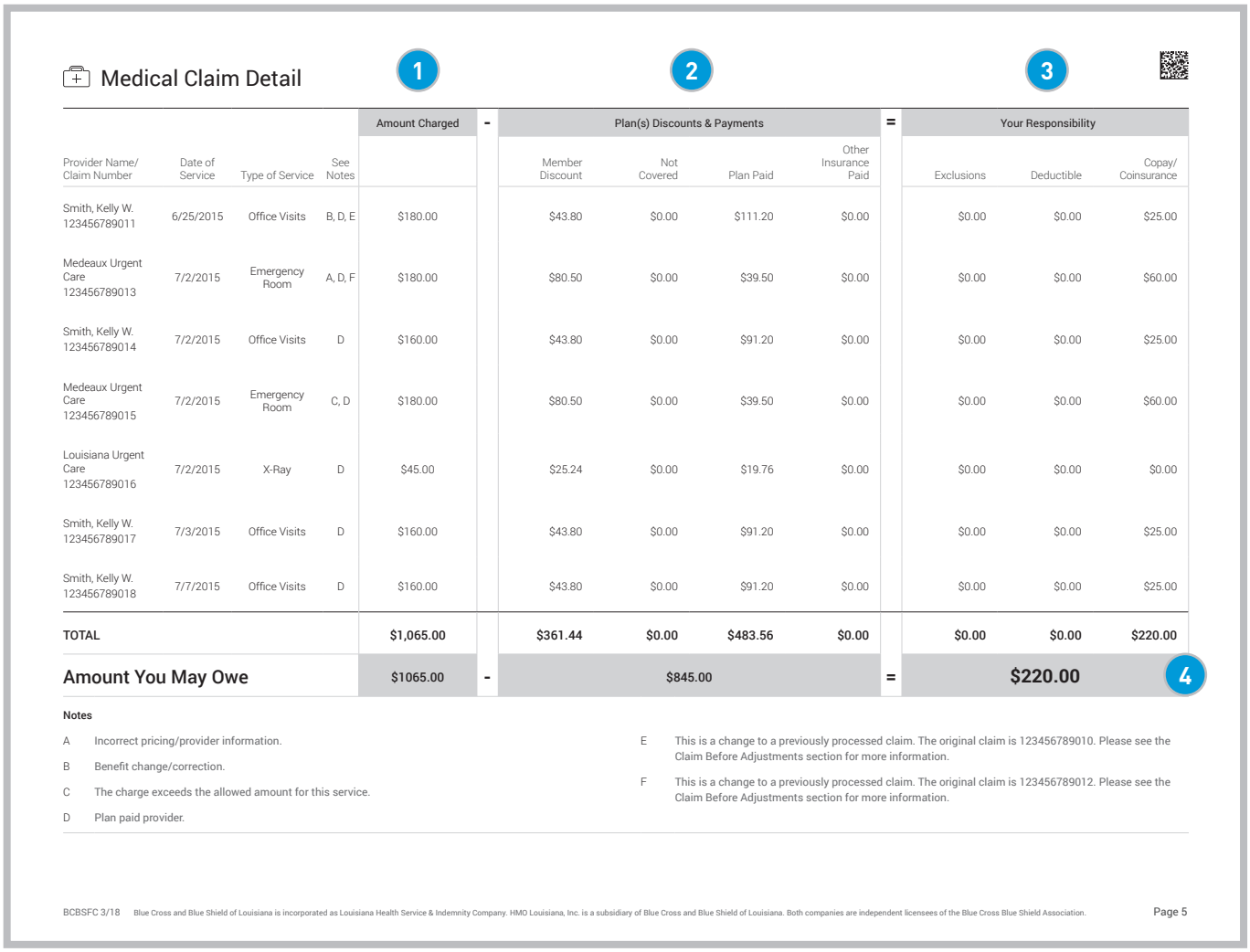
SUMMARY

1 **TOTAL CHARGES**
What the doctor, clinic or hospital charged for care.

2 **PLAN(S) DISCOUNTS & PAYMENTS**
This is your discount on care costs or what your plan paid for care.

3 **AMOUNT YOU MAY OWE**
This is the part of your claims you may have to pay out-of-pocket.

4 **BLUE NEWS**
Look here for messages from us about other services we offer to help you manage your coverage or care.



Medical Claim Detail

1 2 3

Provider Name/ Claim Number	Date of Service	Type of Service	See Notes	Amount Charged	-	Plan(s) Discounts & Payments: Member Discount	Not Covered	Plan Paid	Other Insurance Paid	=	Your Responsibility: Exclusions	Deductible	Copay/ Coinsurance
Smith, Kelly W. 123456789011	6/25/2015	Office Visits	B, D, E	$180.00		$43.80	$0.00	$111.20	$0.00		$0.00	$0.00	$25.00
Medeaux Urgent Care 123456789013	7/2/2015	Emergency Room	A, D, F	$180.00		$80.50	$0.00	$39.50	$0.00		$0.00	$0.00	$60.00
Smith, Kelly W. 123456789014	7/2/2015	Office Visits	D	$160.00		$43.80	$0.00	$91.20	$0.00		$0.00	$0.00	$25.00
Medeaux Urgent Care 123456789015	7/2/2015	Emergency Room	C, D	$180.00		$80.50	$0.00	$39.50	$0.00		$0.00	$0.00	$60.00
Louisiana Urgent Care 123456789016	7/2/2015	X-Ray	D	$45.00		$25.24	$0.00	$19.76	$0.00		$0.00	$0.00	$0.00
Smith, Kelly W. 123456789017	7/3/2015	Office Visits	D	$160.00		$43.80	$0.00	$91.20	$0.00		$0.00	$0.00	$25.00
Smith, Kelly W. 123456789018	7/7/2015	Office Visits	D	$160.00		$43.80	$0.00	$91.20	$0.00		$0.00	$0.00	$25.00
TOTAL				**$1,065.00**		**$361.44**	**$0.00**	**$483.56**	**$0.00**		**$0.00**	**$0.00**	**$220.00**
Amount You May Owe				**$1065.00**	**-**		**$845.00**			**=**		**$220.00**	4

Notes

A Incorrect pricing/provider information.

B Benefit change/correction.

C The charge exceeds the allowed amount for this service.

D Plan paid provider.

E This is a change to a previously processed claim. The original claim is 123456789010. Please see the Claim Before Adjustments section for more information.

F This is a change to a previously processed claim. The original claim is 123456789012. Please see the Claim Before Adjustments section for more information.

MEDICAL CLAIM DETAIL

1 **AMOUNT CHARGED**
What the doctor, clinic or hospital charged for care.

2 **PLAN(S) DISCOUNTS & PAYMENTS**
This is your discount on care costs or what your plan paid for care.

3 **YOUR RESPONSIBILITY**
This is what you must pay for care before your health coverage begins to pay or the parts of your care that are not covered by your plan.

4 **AMOUNT YOU MAY OWE**
This is the part of your claims you may have to pay out-of-pocket.

Mandated Notices

SUMMARY OF PRIVACY PRACTICES NOTICE

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., believe that privacy and confidentiality regarding personal medical information is important to every customer. And securely protecting our customers' privacy is a responsibility we take very seriously.

We want you to know there is a federal regulation that governs the privacy of your medical information and how we use and share that information in the course of our regular business activities. This federal regulation requires us to provide you with a detailed description – or "Notice"– of how we use your medical information.

The attached Notice goes into detail on how we may use and share your medical information in the course of treatment, payment and healthcare (business) operations. In general, unless it is described in the accompanying Notice, we will **not** use or disclose your medical information **without** your written authorization. For example, we may use and disclose your medical information to:

- Enroll you in our plan
- Determine your eligibility for benefits
- Pay your claims
- Underwrite your contract/certificate of coverage
- Share data with your Quality Blue doctor
- Give your healthcare providers updates that help them treat you
- Connect you with Blue Cross health coaches
- Audit our business practices
- Conduct medical reviews
- Conduct quality improvement activities
- Bill you or your employer for your premiums
- Develop strategic business plans
- Remind you about important screenings, shots or tests
- Participate in research, if appropriate regulations are followed
- Improve our services

Your information may be shared with the physicians or other providers who treat you, with other insurance companies, with your employer (following specific guidelines), or with a company we hire to help us do our work. We may also disclose your medical information to your family members, friends and others you choose to involve in your healthcare or in the payment of your healthcare.

Although this occurs rarely, we may also use and disclose your medical information when required by law for various public interest activities, including regulatory oversight of our company (by the Department of Insurance, for example), law enforcement, disaster relief, and certain other public benefit functions.

The federal privacy rules also give you certain rights. Please review this entire Notice to learn about your rights and how to put them to use for you, as well as the procedure to voice complaints regarding our privacy practices.

Maintaining your trust and confidence is our highest priority, and we value your business. Thank you for being our customer.

01MK1780 R05/23

BLUE CROSS AND BLUE SHIELD OF LOUISIANA & HMO LOUISIANA, INC., NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect September 23, 2013, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and send the new Notice to our health plan subscribers at the time of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Medical Information

We will refer to your "health information" throughout this Notice. When we say "health information," we mean what the federal privacy rules ("the HIPAA privacy regulations") call "Protected Health Information." This is individually identifiable health information, including demographic information, collected from you or created or received by a healthcare provider, a health plan, your employer, or a healthcare clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of healthcare to you; (iii) the past, present, or future payment for the provision of healthcare to you. Any terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Regulations as set out in 45 C.F.R. § 164.501.

Required Disclosures of Your Health Information

We **must** disclose your health information:

- To you or someone who has the legal right to act for you (your personal representative), if the information you seek is contained in a designated record set, and
- To the Secretary of the Department of Health and Human Services, if necessary, to investigate or determine our compliance with the HIPAA Privacy Regulations.

Permissive Disclosures of Your Health Information

We **have the right** to use and disclose your health information for:

Treatment: We may disclose your health information to a physician or other healthcare provider to treat you. For example, we may send a copy of a member's medical records we maintain to a physician who needs the additional information to treat the member.

Payment: We may use and disclose your health information to pay claims from physicians, hospitals and other healthcare providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits, and the like. We may disclose your health information to a healthcare provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Healthcare Operations: We may use and disclose your health information for healthcare operations. Healthcare operations include:

- reviewing and evaluating healthcare provider and health plan performance, healthcare provider and health plan accreditation, certification, licensing and credentialing activities;
- healthcare quality assessment and improvement activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage (although we are prohibited from using or disclosing any genetic information for these underwriting purposes); and
- business planning, development, management, and general administration, including customer service, grievance resolution, de-identifying health information, and creating limited data sets for healthcare operations, public health activities and research;
- sharing detailed medical claims and wellness information with your primary care physician to improve care and reduce costs.

For a full list of the activities covered by the terms in this section please consult the definitions set out in 45 C.F.R. § 164.501.

Others Covered by the Privacy Rule: We may disclose your health information to another health plan or to a healthcare provider for certain healthcare operations subject to federal privacy protection laws. We may do so as long as the plan or provider has or had a relationship with you and the health information is for that plan's or provider's healthcare quality assessment and improvement activities, evaluation, or fraud and abuse detection and prevention. For example, we may share your information with your doctors for their licensing or credentialing activities.

Business Associates: We hire individuals and companies to perform various functions on our behalf or to provide certain types of services for us. In order to help us, these business associates may receive, create, maintain, use, or disclose your health information. Before they may have any contact with your health information, we require them to sign a written agreement stating they will keep your health information private and secure.

Examples of our business associates include:

- Medical experts hired to review claims;
- A pharmacy benefits management company hired to assist us in managing pharmacy claims;
- A company hired to conduct data analysis to help us determine which of our programs and services are most helpful to customers, which should be changed and others that we should start.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. However, we will not be able to undo any action that was taken before that authorization was revoked. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this Notice. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of health information for marketing purposes, and disclosures that constitute a sale of protected health information require your authorization.

Family, Friends and Others Involved in Your Care or Payment for Care: Unless you object, we may disclose your health information to a family member, friend or any other person you involve in your healthcare or payment for your healthcare. We will disclose only the health information that is related to the person's involvement. We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your healthcare in appropriate situations, such as medical emergency or during disaster relief efforts (for example, to Red Cross during a natural disaster).

Before we make such a disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your health information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether or not you are enrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is information about claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although this summary health information does not specifically identify any individual, it still may be possible to identify you or others through review of this summary health information.

We may disclose your health information and the health information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must meet certain requirements. This includes amending the plan document for your group health plan to establish the limited uses and disclosures it may make of your health information. Please see your group health plan document for a full explanation of the limitations placed on your employer for the use of this information and for any disclosures that may be made to the group health plan itself.

Health-Related Products and Services: Where permitted by law, we may use your health information to communicate with you about health-related products, benefits and services and payment for those products, benefits and services that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the healthcare providers in our network,

about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan. For example, we may contact you about a Medicare Supplemental policy when you near age 65.

Public Health and Benefit Activities: Although this does not occur often, we may use and disclose your health information when required by law and when authorized by law for the following kinds of public interest activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for healthcare oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research in certain situations, such as when:
  1. an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the information and approved the research or
  2. conducting research with de-identified or limited data sets to learn more about how to help members improve their health;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state workers' compensation laws.

Individual Rights

The following are your rights with respect to your health information. If you would like to exercise any of the following rights, please submit your request in writing, sign your request, and mail it to the Blue Cross and Blue Shield of Louisiana Privacy Office at P.O. Box 84656, Baton Rouge, LA 70884-4656. Our contact information is provided at the end of this Notice.

Access: You have the right to examine and to receive a copy of your health information we maintain about you in a "designated record set," with limited exceptions. This may include an electronic copy in certain circumstances if you make this request in writing.

Generally, a "designated record set" contains:

- claims and payment information;
- enrollment and billing information;
- other records used to make decisions about your healthcare benefits.

We may charge you reasonable, cost-based fees for a copy of your health information, for mailing the copy to you, and for preparing any summary or explanation of your health information you may request. Contact us using the information at the end of this Notice for information about our fees. You may withdraw your request if you do not wish to pay the fees.

In certain situations, we may deny your request to inspect and obtain a copy of your health information. If we deny your request, we will notify you in writing and will inform you whether or not you have the right to have the denial reviewed.

Disclosure Accounting: You have the right to an accounting of certain disclosures that we make of your health information, excluding disclosures for treatment, payment, healthcare operations, as authorized by you, and for certain other activities.

We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this Notice for information about our fees.

Amendment: You have the right to request that we amend your health information that we maintain about you in your designated record set. We may deny your request for certain reasons. For example, we may deny your request if the information you want to amend was created by your doctor. If we deny your request, we will provide you a written explanation, and explain to you how you can disagree with the denial by filing a statement of disagreement with us. If we accept your request, we will make your amendment part of your designated record set, and use reasonable efforts to inform others of the amendment who we know may have relied on the unamended information to your detriment, as well as persons you tell us you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your health information for treatment, payment or healthcare operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will honor our agreement, except in a medical emergency or as required or authorized by law. Any agreement we may make to a request for restriction must be in writing and agreed to by our Privacy Office.

Confidential Communication: If you believe that a disclosure of all or part of your health information may endanger you if sent to your current mailing address, you have the right to request that we communicate with you in confidence about your health information by a different means or to a different location that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.

We will accommodate your request if it is reasonable. You must specify the alternative means of contact or location for confidential communication, and continue to permit us to collect premiums and pay claims under your health plan. Please note that other information that we send to the subscriber about healthcare benefits received may contain sufficient information to reveal that you obtained healthcare for which we paid, even though you

requested that we communicate with you about that healthcare in confidence. If you have given someone else permission to receive health information about you, a request for confidential communications will cancel this permission unless you tell us otherwise.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you have the right to receive this Notice in written form. Please contact us using the information at the end of this Notice to obtain this Notice in written form.

Potential Impact of State Privacy Laws: The federal healthcare Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, or disclosure of health information of minors.

Breach Notification: In the event of a breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this Notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your health information, you may complain to us using the contact information at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-877-696-6775 or visit **www.hhs.gov/ocr/privacy/hipaa/complaints**.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

By mail:
Privacy Office
Blue Cross and Blue Shield of Louisiana
P.O. Box 84656
Baton Rouge, LA 70884-4656

Telephone: (225) 298-1751
Toll free: 1-855-258-3746
Fax: (225) 298-1590
Email: Privacy.Office@BCBSLA.com
(Individual Rights requests will not be accepted via email.)

01MK1780 R05/23

MEMBER DATA PROTECTION STATEMENT

At Blue Cross and Blue Shield of Louisiana, our mission is to improve the health and lives of Louisianians – including by how we store, use and protect our members' data. Blue Cross has strong processes in place, which all of our employees must follow to protect members' data in all forms (spoken, written and/or electronic).

Blue Cross approaches members' data protection from three perspectives – physical security, cybersecurity and privacy. Blue Cross recruits, hires and trains qualified staff who work together to safely store our members' information and make sure all employees are following the laws and regulations that protect it.

Blue Cross has extensive policies and procedures that outline the security and privacy standards and responsibilities for protecting members' data. Employees are trained on Blue Cross data protection protocols as soon as they start working here, and all employees have refresher training at least once a year.

Blue Cross does not give every employee access to members' information, and not all access is the same. How much member information any Blue Cross employee can access depends on his/her job and role within the company. Employees can only get to the information they need to do their jobs and not anything else. For example, a Customer Service adviser who needs member information to answer calls is able to see those records, but a business analyst working on internal projects would not need this access.

Spoken Data

Before Blue Cross employees give information over the phone or in person, they take steps to authenticate the identities of the people requesting information. This is to make sure the people calling are really who they say they are and that they have the right to request that information. Blue Cross has a process for our members to let us know whom they want to be an authorized delegate or legal representative. That means you are giving permission for them to contact Blue Cross and ask for information on your behalf.

Written Data

Blue Cross has strong privacy protection rules for paper documents. Employees are required to keep records in a safe place where they cannot be seen, for example in a locked file cabinet instead of lying on a desk. Blue Cross requires employees to go through their computers and securely destroy electronic files that are no longer needed. This prevents the information in these records from being stolen or accessed by the wrong people.

Electronic Data

Blue Cross IT staff uses the latest technology to keep electronic information secure by encrypting it within internal systems so that no one can get to it from outside the system. The IT staff members have processes in place to detect and prevent hackers from getting to our technical systems and monitor how employees access and use information within the organization.

If you have questions about how Blue Cross uses, stores or protects members' data, call our Information Governance Office at (225) 298-1751.

RIGHTS AND RESPONSIBILITIES

Rights

- You have the right to be provided with information on your health plan, its services, the practitioners providing care and your rights and responsibilities in clear, understandable language.
- You have the right to receive medically necessary care that is covered under your benefit plan and is provided or arranged by your healthcare provider.
- You have the right to be informed by your healthcare provider about your diagnosis, treatment options and prognosis in clear, understandable language.
- You have the right to participate with practitioners when making decisions regarding your healthcare.
- You have the right to refuse treatment.
- You have the right to be treated with respect and recognition of your dignity and privacy.
- You have the right to the confidentiality of information concerning your medical treatment.
- You have the right to express verbal or written complaints about Blue Cross/HMO Louisiana or the medical care provided, and to a timely response when appropriate.
- You have the right to a candid discussion of all appropriate, medically necessary options for your condition(s), regardless of cost or benefit coverage.
- You have the right to know how your physician and other healthcare professionals are compensated by Blue Cross/HMO Louisiana.
- You have the right to make recommendations to your health plan on its Member Rights and Responsibilities policy.

Responsibilities

- You are responsible for reading and understanding all material concerning your health benefits.
- You are responsible for complying with all terms of membership with your health plan.
- You are responsible for developing and maintaining a satisfactory physician-patient relationship.
- You are responsible for following instructions and guidelines as agreed upon by you and your healthcare provider.
- You are responsible for engaging in a healthy lifestyle and in safety practices.
- You are responsible for providing, to the extent possible, complete and accurate information that Blue Cross/HMO Louisiana and its practitioners and providers need in order to care for you.
- You are responsible for making and keeping appointments, or canceling in advance if unable to make your appointment.
- You are responsible for paying copayment and/or coinsurance amounts required under your health plan.
- You are responsible for notifying your employer or Blue Cross of any other healthcare coverage of which you are a beneficiary, and for cooperating in coordinating benefits.
- You are responsible for understanding your health conditions and participating in developing mutually agreed-upon treatment goals, to the degree possible.

01MK6155 R09/19

YOUR RIGHTS REGARDING THE RELEASE OF GENETIC INFORMATION

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., shall not, solely on the basis of any genetic information concerning an individual or family member or solely on the basis of an individual's or family member's request for or receipt of genetic services, or refusal to submit to a genetic test or make available the results of a genetic test:

1. Terminate, restrict, limit or apply conditions to the coverage provided under the policy or plan, or restrict the sale of the policy or plan to an individual or family member;
2. Cancel or refuse to renew the coverage of an individual or family member under the policy or plan;
3. Deny coverage or exclude an individual or family member from coverage under the policy or plan;
4. Impose a rider that excludes coverage for certain benefits or services under the policy or plan;
5. Establish differentials in premium rates or cost-sharing for coverage under the policy or plan; or
6. Otherwise discriminate against an individual or family members in the provision of insurance.

Blue Cross and Blue Shield of Louisiana and its affiliate, HMO Louisiana, Inc., are prohibited by law from requiring any applicant or subscriber to undergo genetic testing or to be subjected to questions relating to genetic information.

As provided by law, "genetic information" means all information about genes, gene products, inherited characteristics or family history/pedigree as expressed in common language.

40XX0908 R09/22

BALANCE BILLING DISCLOSURE NOTICE REQUIRED BY LOUISIANA LAW

HEALTHCARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTHCARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES AND NONCOVERED SERVICES.

SPECIFIC INFORMATION ABOUT NETWORK AND NON-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT **BCBSLA.COM** OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER ON THE BACK OF YOUR ID CARD.

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTHCARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS UNDER FEDERAL LAW

When you get emergency care or get treated by an out-of-network provider at a network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is a balance or surprise bill? Surprise or balance billing is when an out-of-network provider bills you for more than what your plan pays a network provider for the same care.

Out-of-network providers may bill you for more than what your plan pays a network provider for the same kind of care. Out-of-network providers cannot send you an unexpected bill when you cannot choose who treats you. Out-of-network providers who see you in a true health emergency cannot send you a bill for more than what your plan pays. In most cases, out-of-network providers who see you in a network hospital cannot send you a bill for more than what your plan pays without your consent.

You are protected from balance billing for:

- Emergency services: If you must get care in a true emergency from an out-of-network provider, the most the provider may bill you is your plan's copayment, coinsurance or deductible for network care. You cannot be balance billed for these emergency services. This includes care you may get after you are in stable condition unless you give written consent and give up your protections not to be balanced billed.
- Certain services at a network hospital or ambulatory surgical center: When you get services from a network hospital or ambulatory surgical center, certain providers there may be out-of-network. **In most cases, out-of-network providers who see you in a network hospital (anesthesiologists, emergency room doctors, neonatologists, pathologists, radiologists and others) cannot send you a surprise bill.** These providers may not ask you to give up your protections not to be balance billed.

If you get other care at these network facilities, out-of-network providers cannot balance bill you unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:
You are only responsible for paying any copayments, coinsurance or deductible that you would pay if the provider was in your network. Your health plan will pay the out-of-network providers and facilities. Your health plan generally must:

- Cover emergency services without requiring you to get approval for care in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay a network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your network deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact 1-800-985-3059 or visit **cms.gov/nosurprises** for more information about your rights under federal law.

Find more information about surprise or balance billing at **bcbsla.com/hbp**.

13LG0011 R08/22

NOTICE OF SPECIAL ENROLLMENT RIGHTS

This notice is applicable to only those enrolling or eligible to enroll in fully insured small and large group health products. Applicable to grandfathered and non-grandfathered plans.

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify eligible plan participants about the right to enroll in the plan under its "special enrollment provision," if you decline coverage or if you acquire a new dependent.

Loss of Other Coverage for Large Group Members and Loss of Minimal Essential Coverage for Small Group Members (Excluding Medicaid or State Children's Health Insurance Program) - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within thirty (30) days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Individuals who lose other coverage because they do not pay their premium or required contributions or lose other coverage for cause (such as filing fraudulent claims or intentional misrepresentation of a material fact in connection with the plan) are not special enrollees and have no special enrollment rights.

Loss of Coverage for Medicaid or a State Children's Health Insurance Program – If you decline enrollment for yourself or for an eligible dependent (including your spouse) because Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. You must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption - If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as special enrollees. You must request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your employer (plan administrator) or our Customer Service Center at 1-800-495-2583.

01MK1663 R01/19

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ENROLLMENT NOTICE FOR ALL COVERED MEMBERS

If you have had or are going to have a mastectomy, you may be entitled to certain Benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed or reconstruction of both breasts if a bilateral mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including but not limited to contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future;
- Prostheses; and
- Treatment of physical complications of all stages of the mastectomy, including lymphedema.

Certain breast cancer survivors are eligible to receive annual preventive cancer screenings as part of long-term survivorship care. You are eligible for these screenings if You:

- were previously diagnosed with breast cancer;
- completed treatment for breast cancer;
- underwent bilateral mastectomy; and
- were subsequently determined to be clear of cancer.

These Benefits will be provided in a manner determined in consultation with the attending Physician and the patient, and subject to the same Deductible Amount, Coinsurance, and Copayments applicable to other medical and surgical Benefits provided under this plan. Information on the plan's specific Deductible Amount, Coinsurance, or Copayment will be shown on the Schedule of Benefits.

If you have questions about this notice or about the coverage described herein, please contact our customer service department at the number listed on the back of the ID card.

HMO LOUISIANA, INC., ENROLLMENT NOTICE

NOTICE - YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE Healthcare NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

This notice is applicable only to those enrolling in fully insured HMO or POS products.

HMO Louisiana, Inc. (HMOLA), is required to disclose the following information to its members upon enrollment. This disclosure provides you with general information about your HMO/POS plan. Please refer to your Schedule of Benefits for specific copayment, deductible and coinsurance amounts and network information. Your Policy or Schedule of Benefits includes specific information about your covered benefits.

Copayment, Deductible and Coinsurance Amounts

As an HMOLA member, you are responsible for copayment, deductible and coinsurance amounts as outlined in your Policy or Certificate of Coverage. A copayment is a fixed dollar amount that you pay when you receive services from a network provider. Different copayment amounts apply to primary care physicians and specialists. You are generally responsible for a copayment when covered services are rendered by network providers. A deductible applies to out-of-network benefits. Use your plan's in-network providers to ensure the lowest member out-of-pocket cost. Using out-of-network providers may result in denial of benefits or higher member out-of-pocket costs. Please see your Policy or Certificate of Coverage for details.

Provider Networks

Community Blue Network. Community Blue members receive in-network benefits when they obtain services from the specially-developed Community Blue network of providers. Services obtained from providers outside of the Community Blue network are available but will result in higher out-of-pocket costs.

BlueConnect Network. BlueConnect members receive in-network benefits when they obtain services from the specially-developed BlueConnect network of providers. Services obtained from providers outside of the BlueConnect network are available but will result in higher out-of-pocket costs.

Signature Blue Network. Signature Blue members receive in-network benefits when they obtain services from the specially-developed Signature Blue network of providers. Services obtained from providers outside of the Signature Blue network are available but will result in higher out-of-pocket costs.

Precision Blue Network. Precision Blue members receive in-network benefits when they obtain services from the specially-developed Precision Blue network of providers. Services obtained from providers outside of the Precision Blue network are available but will result in higher out-of-pocket costs.

HMO Network. HMO members use the HMO network and will be denied coverage when they use out-of-network providers.

POS Network. POS members receive in-network benefits when they obtain services from the HMO network of providers and will have higher out-of-pocket expenses when they obtain services from outside of this network.

Please go to **www.bcbsla.com/findcare** for more information about our provider networks.

Choice of Primary Care Providers

Community Blue, BlueConnect, Signature Blue, Precision Blue, HMO and POS. Community Blue, BlueConnect, Signature Blue, Precision Blue, HMO and POS health plan members are required to select primary care providers (PCPs) from their respective networks. If a PCP selection is not initially made, HMOLA will designate a PCP until one is selected by the member.

Members may select a PCP from the applicable HMO Louisiana, Inc., network of physicians from the following practice areas:

- Family Practice/General Practice: physicians who are trained in all aspects of primary medical treatment and are able to diagnose and treat patients in all age groups

- Internal Medicine: physicians who treat routine and complex adult medical conditions
- Pediatrics: physicians who specialize in the treatment of children
- Geriatrics: physicians who specialize in treating older adults
- Nurse Practitioner: nurses who are qualified to treat certain medical conditions directly, without a doctor's supervision; must be set up in our system as a network PCP
- Physician Assistant: clinical staff trained to treat common medical conditions, usually under a doctor's supervision; must be set up in our system as a network PCP

Members may choose a separate PCP for themselves, their spouse and each of their eligible dependents, or they may choose one PCP for the entire family.

Direct Access to Specialists

Our members may access most network specialists directly, without a referral from their PCP. Your Policy or Schedule of Benefits defines the specialists and services that require authorization prior to obtaining services.

Treatment of Pre-existing Conditions

We do not exclude benefits because of a pre-existing condition.

If you have any questions about this disclosure or your HMOLA coverage, please call Customer Service at 1-800-495-2583 between 8 a.m. and 8 p.m., Monday through Friday.

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, LA 70804	LA Department of Insurance P.O. Box 94214 Baton Rouge, LA 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. Exclusions 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 healthcare 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.

23XX0534 R08/18

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)

GETTING IN TOUCH WITH US

Alexandria
318-448-1660
4508 Coliseum Blvd., Suite A
Alexandria, LA 71303

Baton Rouge
225-295-2556
5525 Reitz Ave.
Baton Rouge, LA 70809-3802

Houma
985-223-3499
1437 St. Charles St., Suite 135
Houma, LA 70360

Lafayette
337-232-7527
5501 Johnston St.
Lafayette, LA 70503

Lake Charles
337-562-0595
219 West Prien Lake Rd.
Lake Charles, LA 70601-8450

Monroe
318-323-1479
122 St. John St.
Monroe, LA 71201

New Orleans
504-832-5800
3235 North Causeway Blvd.
Metairie, LA 70002

Or

504-518-7364
Orleans Tower
1340 Poydras St., Suite 100
New Orleans, LA 70112

Shreveport
318-795-0573
411 Ashley Ridge Blvd.
Shreveport, LA 71106

Toll-free Customer Service
1-800-392-4087

Email
help@bcbsla.com

On the Web
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