Louisiana

BlueChoice 65, BlueChoice 65 SELECT, BlueChoice 65 PLUS & BlueChoice 65 SELECT PLUS

Medicare Supplement Programs

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD ON OR AFTER JANUARY 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

NOTE: A ✓ MEANS 100% OF THE BENEFITS IS PAID.

Benefits	Plans available to all applicants								Medicare first eligible before 2020 only	
	A	B†	D	G[1‡]	K	L	M	N†	C	F[1†Δ]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓					✓	✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					$7,060[2]	$3,530[2]				

[1]Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

†If you choose the BlueChoice 65 SELECT Plan B, F, G,N, or the BlueChoice 65 SELECT PLUS Plan G, you must use a network hospital for inpatient hospital services. No policy benefits will be provided for inpatient hospital services in a non-network hospital, except for emergency treatments.

ΔPlans F and F SELECT are not available to those that become newly Medicare eligible on or after 1/1/2020.

‡Plus Plan G and Select Plus Plan G includes dental services. Advantage Plus Network is administered by United Concordia Companies, Inc. United Concordia is an independent company that administers dental benefits on behalf of Blue Cross and Blue Shield of Louisiana members.

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Premium Information

We at Blue Cross and Blue Shield of Louisiana can raise your premium only if we raise the premium for all policies like yours in this state. Your premium will change as you enter a new age bracket or move to a new area. Our age brackets and areas are defined on the chart below. Premiums may be paid on a monthly, quarterly, semi-annual or annual basis. Monthly premiums are shown below.

Monthly Premiums
Effective 5-1-2023

Area I
(All parishes in the state except the Area II parishes listed below)

Age	BC 65 Plan A	BC 65 Plan B	BC 65 SELECT Plan B	BC 65 Plan F	BC 65 SELECT Plan F	BC 65 Plan G	BC 65 SELECT Plan G	BC 65 PLUS Plan G	BC 65 SELECT PLUS Plan G	BC 65 Plan N	BC 65 SELECT Plan N
Under 65	374.50	500.20	343.10	989.30	435.30	643.90	346.90	666.90	369.90	331.20	235.20
65	130.30	169.60	116.90	199.70	148.50	128.50	95.60	151.50	118.60	97.00	72.20
66-68	141.10	184.40	126.80	217.10	161.60	139.70	103.90	162.70	126.90	105.50	78.50
69-71	152.90	201.10	138.30	236.70	176.40	152.30	113.40	175.30	136.40	115.00	85.80
72-74	161.80	213.40	146.80	251.40	187.50	161.80	120.60	184.80	143.60	122.10	91.10
75-77	171.90	228.30	157.30	270.30	201.60	174.00	129.60	197.00	152.60	131.60	98.00
78-80	179.20	238.90	164.20	282.90	210.50	182.10	135.50	205.10	158.50	137.70	102.40
81+	186.80	249.20	171.20	294.80	216.60	189.70	139.40	212.70	162.40	143.50	105.20

Area II
(Orleans, Jefferson, Plaquemines, St. Bernard, St. Charles, St. Tammany and Washington Parishes)

Age	BC 65 Plan A	BC 65 Plan B	BC 65 SELECT Plan B	BC 65 Plan F	BC 65 SELECT Plan F	BC 65 Plan G	BC 65 SELECT Plan G	BC 65 PLUS PLAN G	BC 65 SELECT PLUS Plan G	BC 65 Plan N	BC 65 SELECT Plan N
Under 65	432.70	577.90	396.30	1,143.20	503.10	744.20	400.60	767.20	423.60	382.90	271.70
65	150.70	196.20	134.80	230.70	171.80	148.40	110.40	171.40	133.40	112.10	83.60
66-68	162.90	213.10	146.70	251.00	186.70	161.40	120.10	184.40	143.10	122.00	90.70
69-71	176.60	232.00	159.60	273.70	203.80	176.00	131.10	199.00	154.10	133.00	99.10
72-74	186.90	246.20	169.60	290.30	216.60	186.70	139.40	209.70	162.40	141.10	105.20
75-77	198.30	264.20	181.90	312.00	232.90	200.70	149.80	223.70	172.80	151.70	113.10
78-80	207.10	275.70	189.70	326.60	243.00	210.10	156.30	233.10	179.30	158.90	118.00
81+	215.40	287.80	197.80	341.20	249.90	219.40	160.90	242.40	183.90	165.90	121.60

BlueChoice 65, BlueChoice 65 SELECT, BlueChoice 65 PLUS and BlueChoice 65 SELECT PLUS are not connected with or endorsed by the U.S. government or the federal Medicare program.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010.

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all the rights and duties of both you and your insurance company.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Louisiana with a written request to cancel. (Attention: Individual Membership and Billing, P.O. Box 98029, Baton Rouge, LA 70898-9029). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments. If you have questions, you may call our Customer Service Department at **1-800-258-3365** between 8 a.m. and 4 p.m.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you actually have received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs. Neither Blue Cross and Blue Shield of Louisiana nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office, consult *"The Medicare & You Handbook,"* or go online at **www.medicare.gov** for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you omit or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

MEDICARE SELECT AND SELECT PLUS ADDITIONAL DISCLOSURES

The Medicare SELECT Plans currently offered by BCBSLA are Plans B, F, G and N.

The Medicare SELECT PLUS Plans currently offered by BCBSLA is Plan G.

Understanding Medicare SELECT

The Blue Cross and Blue Shield of Louisiana BlueChoice (BC) 65 includes SELECT and SELECT PLUS Plans which will offer coverage which is comparable to BCBSLA's current Medicare Supplement Plans at a competitive premium for services received within network.

Restricted Network Provisions

Part A: Payment of Part A (Hospital) benefits may be denied if you receive services at a hospital that is not a Network Hospital.

Part B: Payment of Part B (outpatient) benefits is not subject to any network restrictions and will be paid according to the same terms as a standard Medicare Supplement Insurance Plan.

Availability of Emergency Care

Benefits are available for emergency situations at any provider on the same basis as care received from a BC 65 SELECT Network Provider if it is not reasonable to obtain such services through a Network Provider.

Emergency or Life Threatening Illness is defined as the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical care could reasonably result in: (1) permanently placing the patient's health in jeopardy; (2) serious impairment of bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences; or (4) for which death is probable.

Referrals

There are no restrictions on referrals to other hospitals for inpatient care if referred by a Network Hospital and this referral is approved by us in advance. Additionally, there are no restrictions on referrals for outpatient providers regardless of whether that provider is in the service area.

Availability of Other Medicare Supplement Plans

Blue Cross and Blue Shield of Louisiana offers Standard Medicare Supplement Plans. Any of these plans are available for you to purchase now or at any time you wish to convert from a Medicare SELECT or SELECT PLUS plan. You also have the right to convert to any Medicare Supplement policy we have available with comparable or lesser benefits if the Medicare SELECT or SELECT PLUS program is discontinued, or you move outside of the service area and your new residence is not within a reasonable travel distance of a Network Hospital.

Quality Assurance

Each Network Hospital within the service area has appropriate state licensing and is Medicare certified. All hospitals within the network have an appropriate mix of physician specialties for covered services provided by the hospital. When using a Network Hospital you are assured that the care you receive meets or exceeds the acceptable standards of quality for the hospital industry.

COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

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

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

A. Complaint and Grievance Procedures

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

1. To register a complaint

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

2. To file a formal grievance

A grievance is a written expression of dissatisfaction with Us or with provider services. If You do not feel Your complaint was adequately resolved or You wish to file a formal grievance, a written request must be submitted within one hundred eighty (180) days of the event that led to the dissatisfaction. For assistance, You may call Our customer service department.

Send Your written grievance to:

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

A response will be mailed to You within thirty (30) business days of receipt of Your written grievance.

B. Appeals Procedures

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

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

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

You have the right to appoint an authorized representative to represent You in Your appeal. An authorized representative is a person to whom You have given written consent to represent You in review of a denial. The authorized representative may be Your treating provider, if You appoint the provider in writing.

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

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

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

Appeals should be submitted in writing to:

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

1. **First Level Appeals**

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

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

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

2. **Second Level Appeals**

   After review of Our second level appeal decision, if You are still dissatisfied, a written request to Appeal must be submitted within sixty (60) days of Our first level Appeal decision. Requests submitted to Us after sixty (60) days of Our first level Appeal decision will not be considered.

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

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

BLUECHOICE 65 PLAN A
Medicare (Part A) — Hospital Services — Per Benefit Period

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
Days 1-60:	All but $1,632	$0	$1,632 (Part A Deductible)
Days 61-90:	All but $408 a day	$408 a day	$0
Days 91 and beyond: — While using 60 lifetime reserve days — Once lifetime reserve days are used:	All but $816 a day	$816 a day	$0
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20:	All approved amounts	$0	$0
Days 21-100:	All but $204 a day	$0	Up to $204 a day
Days 101 and beyond:	$0	$0	All costs
BLOOD First three pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

BLUECHOICE 65 PLAN A (Continued)
Medicare (Part B) — Medical Services — Per Calendar Year

***Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT (such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

BLUECHOICE 65 PLAN B & BLUECHOICE 65 SELECT PLAN B
Medicare (Part A) — Hospital Services — Per Benefit Period

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

****If you choose BlueChoice 65 SELECT Plan B, you must use a network hospital for these benefits. These benefits will not be provided if you are hospitalized in a non-network hospital, unless the hospitalization is for emergency treatment as described in the policy.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
Days 1-60:	All but $1,632	$1,632 (Part A Deductible)**	$0
Days 61-90:	All but $408 a day	$408 a day**	$0
Days 91 and beyond: — While using 60 lifetime reserve days	All but $816 a day	$816 a day**	$0
— Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20:	All approved amounts	$0	$0
Days 21-100:	All but $204 a day	$0	Up to $204 a day
Days 101 and beyond:	$0	$0	All costs
BLOOD First three pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

BLUECHOICE 65 PLAN B & BLUECHOICE 65 SELECT PLAN B (Continued)
Medicare (Part B) — Medical Services — Per Calendar Year

***Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT (such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

BLUECHOICE 65 PLAN F & BLUECHOICE 65-SELECT PLAN F[Δ]
Medicare (Part A) — Hospital Services — Per Benefit Period

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

****If you choose BlueChoice 65 SELECT Plan F, you must use a network hospital for these benefits. These benefits will not be provided if you are hospitalized in a non-network hospital, unless the hospitalization is for emergency treatment as described in the policy.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
Days 1-60:	All but $1,632	$1,632 (Part A Deductible)**	$0
Days 61-90:	All but $408 a day	$408 a day**	$0
Days 91 and beyond:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day**	$0
— Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20:	All approved amounts	$0	$0
Days 21-100:	All but $204 a day	Up to $204 a day	$0
Days 101 and beyond:	$0	$0	All costs
BLOOD			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[Δ]Plans F and F SELECT are not available to those that become newly Medicare eligible on or after 1/1/2020.

BLUECHOICE 65 PLAN F & BLUECHOICE 65 SELECT PLAN F[Δ] (Continued)
Medicare (Part B) — Medical Services — Per Calendar Year

***Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT (such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $240 of Medicare-approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

HOME HEALTHCARE MEDICARE-APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits - Not Covered by Medicare

FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[Δ]Plans F and F SELECT are not available to those that become newly Medicare eligible on or after 1/1/2020.

BLUECHOICE 65 PLAN G & BLUECHOICE 65-SELECT PLAN G
Medicare (Part A) — Hospital Services — Per Benefit Period

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

**** If you choose BlueChoice 65 SELECT Plan G, you must use a network hospital for these benefits. These benefits will not be provided if you are hospitalized in a non-network hospital, unless the hospitalization is for emergency treatment as described in the policy.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
Days 1-60:	All but $1,632	$1,632 (Part A Deductible)**	$0
Days 61-90:	All but $408 a day	$408 a day**	$0
Days 91 and beyond:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day**	$0
— Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20:	All approved amounts	$0	$0
Days 21-100:	All but $204 a day	Up to $204 a day	$0
Days 101 and beyond:	$0	$0	All costs
BLOOD			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

BLUECHOICE 65 PLAN G & BLUECHOICE 65 SELECT PLAN G (Continued)
Medicare (Part B) — Medical Services — Per Calendar Year

***Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT (such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

HOME HEALTHCARE MEDICARE-APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits – Not Covered by Medicare

FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

BLUECHOICE 65 PLUS PLAN G & BLUECHOICE 65 SELECT PLUS PLAN G
Medicare (Part A) — Hospital Services — Per Benefit Period

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

****If you choose BlueChoice 65 SELECT PLUS Plan G, you must use a network hospital for these benefits. These benefits will not be provided if you are hospitalized in a non-network hospital, unless the hospitalization is for emergency treatment as described in the policy.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
Days 1-60:	All but $1,632	$1,632 (Part A Deductible)**	$0
Days 61-90:	All but $408 a day	$408 a day**	$0
Days 91 and beyond: — While using 60 lifetime reserve days — Once lifetime reserve days are used:	All but $816 a day	$816 a day**	$0
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20:	All approved amounts	$0	$0
Days 21-100:	All but $204 a day	Up to $204 a day	$0
Days 101 and beyond:	$0	$0	All costs
BLOOD First three pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

BLUECHOICE 65 PLUS PLAN G & BLUECHOICE 65 SELECT PLUS PLAN G
Medicare (Part B) — Medical Services — Per Calendar Year

***Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT (such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

HOME HEALTHCARE MEDICARE-APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits – Not Covered by Medicare

FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

BLUECHOICE 65 PLUS PLAN G & BLUECHOICE 65 SELECT PLUS PLAN G
Dental Services — Per Calendar Year

- **In order to receive full benefits, dental services must be performed by a provider in the United Concordia Dental Advantage Plus Network.**
- **Annual allowance of $1,200 per year for all dental services combined, preventive and basic.**

DENTAL SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PREVENTIVE SERVICES			
Oral Exams – Limited to 2 exam(s) every year	$0	100%	$0
Routine Cleaning – Limited to 2 cleaning(s) every year	$0	100%	$0
Horizontal Bitewing X-rays – Limited to 1 set every year	$0	100%	$0
BASIC SERVICES			
Adjustments of Prosthetics – Up to 1 per arch per 2 years	$0	100%	$0
Repairs of Prosthetics – Up to 1 arch per 3 years	$0	100%	$0
Amalgam Replacement Restoration (Metal Fillings) – Limited to 1, per tooth, every 36 months	$0	100%	$0
Resin-based Composite Replacement Restoration (Anterior) – Limited to 1, per tooth, every 36 months	$0	100%	$0
Endodontic Therapy and Services – Limited to 1 visit per tooth per lifetime	$0	100%	$0
Palliative Treatment (ER) – Limited to 1 visit per year	$0	100%	$0
Extractions – No limit to simple surgical extractions	$0	100%	$0

BLUECHOICE 65 PLAN N & BLUECHOICE 65 SELECT PLAN N
Medicare (Part A) — Hospital Services — Per Benefit Period

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

****If you choose BlueChoice 65 SELECT Plan N, you must use a network hospital for these benefits. These benefits will not be provided if you are hospitalized in a non-network hospital, unless the hospitalization is for emergency treatment as described in the policy.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
Days 1-60:	All but $1,632	$1,632 (Part A Deductible)**	$0
Days 61-90:	All but $408 a day	$408 a day**	$0
Days 91 and beyond: — While using 60 lifetime reserve days — Once lifetime reserve days are used:	All but $816 a day	$816 a day**	$0
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20:	All approved amounts	$0	$0
Days 21-100:	All but $204 a day	Up to $204 a day	$0
Days 101 and beyond:	$0	$0	All costs
BLOOD First three pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

BLUECHOICE 65 PLAN N & BLUECHOICE 65 SELECT PLAN N (continued)
Medicare (Part B) — Medical Services — Per Calendar Year

***Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT (such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (Above Medicare-approved amounts)	$0	$0	All Costs
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

HOME HEALTHCARE MEDICARE-APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits Not Covered by Medicare

FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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)

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Blue Cross and Blue Shield of Louisiana
Individual Sales and Medicare Customer Service Centers

Alexandria
4508 Coliseum Boulevard
Suite A
Alexandria, LA 71303
318-442-8107

Baton Rouge
5525 Reitz Avenue
Baton Rouge, LA 70809-3802
225-295-2527
Medicare Customer Service:
225-295-0334

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

Lafayette
5501 Johnston Street
Suite 200
Lafayette, LA 70503
337-231-0005

Lake Charles
219 W. Prien Lake Road
Lake Charles, LA 70601
337-480-5315

Monroe
2360 Tower Drive
Suite 102
Monroe, LA 71201
318-398-4955

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

New Orleans
1340 Poydras Street
Suite 100
New Orleans, LA 70112
504-518-7364

Shreveport
411 Ashley Ridge Boulevard
Shreveport, LA 71106
318-795-4911

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