BlueChoice 65
A Medicare Supplement Program

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD FOR EFFECTIVE DATES ON OR AFTER JUNE 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in Louisiana.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:
- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance

A	B†	C	D	F†	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N†
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $4620; paid at 100% after limit reached	Out-of-pocket limit $2310; paid at 100% after limit reached		

†If you choose the BlueChoice 65 SELECT policy, Plans B, F, or N, 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.
*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

23XX2475 R4/10 Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

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

Area I

(all parishes in the state except the Area II parishes listed below)

Age	Blue*Choice 65* Plan A	Blue*Choice 65* Plan B	Blue*Choice 65 Select* Plan B	Blue*Choice 65* Plan F	Blue*Choice 65 Select* Plan F	Blue*Choice 65* Plan N	Blue*Choice 65 Select* Plan N
Under 65	$196.00	$261.70	$162.70	$288.00	$210.60	$230.20	$156.00
65	107.20	139.50	87.10	152.50	113.40	121.90	84.00
66-68	116.10	151.80	94.60	165.70	123.40	132.40	91.40
69-71	125.80	165.50	103.10	180.80	134.70	144.50	99.80
72-74	133.10	175.60	109.40	192.00	143.20	153.40	106.10
75-77	141.50	187.90	117.20	206.50	153.90	165.00	114.00
78-80	147.50	196.60	122.40	216.20	160.80	172.80	119.10
81+	153.60	205.00	127.70	225.30	165.40	180.10	122.50

Area II

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

Age	Blue*Choice 65* Plan A	Blue*Choice 65* Plan B	Blue*Choice 65 Select* Plan B	Blue*Choice 65* Plan F	Blue*Choice 65 Select* Plan F	Blue*Choice 65* Plan N	Blue*Choice 65 Select* Plan N
Under 65	$226.40	$302.40	$187.90	$332.90	$243.30	$266.10	$180.20
65	124.00	161.40	100.60	176.20	131.20	140.80	97.20
66-68	134.00	175.30	109.30	191.60	142.50	153.10	105.60
69-71	145.20	190.90	119.00	209.00	155.70	167.00	115.30
72-74	153.70	202.50	126.40	221.70	165.40	177.20	122.50
75-77	163.20	217.30	135.50	238.40	177.80	190.50	131.70
78-80	170.40	226.80	141.50	249.50	185.60	199.40	137.50
81+	177.20	236.80	147.50	260.60	191.00	208.30	141.50

BlueChoice 65 BlueChoice 65 SELECT

BlueChoice 65 and ***BlueChoice 65 SELECT*** 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. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.

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 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.

COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when You are unhappy about the care and/or services You receive from Us or if you have a Blue Choice 65 Select Medicare Supplement policy, from one of Our Select network 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 unhappy about decisions that we make regarding covered services. We consider your request to change our coverage decision as an appeal. We define an appeal as a request from an insured or authorized representative to change a previous decision made by the company about covered services. Examples of issues that qualify as appeals include denied authorizations, claims based on adverse determinations of medical necessity, or benefit determinations.

Your appeal rights are outlined below, after the Complaint and Grievance Procedure section. In addition to the appeals rights, your provider is given an opportunity to speak with a Medical Director for an informal reconsideration of our coverage decision.

We have an expedited appeals process for situations where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. That process is outlined following the Standard Appeal Procedure section.

Complaint and Grievance Procedure

A **complaint** is an oral expression of dissatisfaction with us or with provider services. A quality of care concern addresses the appropriateness of care given to you. A quality of service concern addresses our services, access, availability or attitude and if you have a Blue Choice 65 Select Medicare Supplement policy, those of Our Select network providers.

To register a complaint:

Call our Customer Service Department at 1-800-376-7741 or 1-225-293-0625. We will attempt to resolve your complaint at the time of your call.

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, you must submit this in writing. Our Customer Service Department will assist you if necessary. 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 30 business days after we receive your written grievance. If you are not happy with our handling of your grievance, you have the right to elevate your grievance to the second and final level. We must receive your request for a second level grievance no later than sixty (60) calendar days from date we notified you of the answer to the first level grievance. Grievances received after this date will not be considered. Each level of the grievance procedure is reviewed by a separate panel.

Informal Reconsideration

An **informal reconsideration** is your provider's telephone request to speak to our Medical Director or a peer reviewer on your behalf about a utilization management decision that we have made. An informal reconsideration is typically based on submission of additional information or a peer-to-peer discussion. An informal reconsideration is available only for initial or concurrent review determinations that are requested within 10 days of the denial. We will conduct an informal reconsideration within one working day of the receipt of the request.

Standard Appeal Procedure

Multiple requests to appeal the same claim, service, issue, or date of service will not be considered, at any level of review. We recognize that disputes may arise between us and our members regarding covered services. An **appeal** is a written request from you to change a prior decision that we have made. Examples of issues that qualify as appeals include denied authorizations, denied claims or determinations of medical necessity. We will distinguish your appeal as either an administrative appeal or a medical necessity appeal.

We intend to make the appeals process one of timely response, timely documentation and timely resolution of such disputes. The procedure has (2) internal levels, including review by a committee at the second level. You are encouraged to provide us with all available information to help us completely evaluate your appeal. Medical necessity appeals also offer you the opportunity to appear in person or by telephone at a committee meeting as well as an opportunity for review by an independent external review organization.

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 an internal or external review of a denial. The authorized representative may be your treating provider, if you appoint the provider in writing and the provider agrees and waives in writing any right to payment from you other than any applicable coinsurance amount. Providers will be notified of the appeal result only if the provider filed the appeal.

First Level of Internal Appeal

If you are not satisfied with our denial of services, you, your authorized representative or a provider acting on your behalf must submit his initial written request to appeal within 180 days following insured's receipt of an initial adverse benefit determination. 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

If you have questions or need assistance putting the appeal in writing, you may call our Customer Service Department at 1-800-376-7741 or 1-225-293-0625. Requests submitted to us after 180 days of the denial will not be considered.

We will investigate your concerns. All appeals of medical necessity denials will be reviewed by a physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. If our initial denial is overturned on your administrative or medical necessity appeal, we will process your claim and will notify you and all appropriate providers, in writing, of the first-level appeal decision. If your claim is denied on appeal, we will notify you and all appropriate providers when applicable, in writing, of our decision. The decision will be mailed within 30 working days of your request, unless you, your authorized representative and we mutually agree that an extension of the time is warranted. At that time, we will inform you of your right to begin the second-level appeal process.

Second Level of Internal Appeal

Within 60 calendar days of the date of our first-level appeal decision, an insured who is not satisfied with the decision may initiate, with assistance from the Customer Service Unit, if necessary, the second level of the appeal process, by writing to:

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

If you have questions or need assistance putting the appeal in writing, you may call the Customer Service Department at 1-800-376-7741 or 1-225-293-0625. Requests submitted to us after 60 days of the denial will not be considered.

A Member Appeals Committee not involved in any previous denial will review all second-level appeals. For medical necessity appeals only, we will advise you or your authorized representative of the date and time of the review meeting, which you or your authorized representative may attend. The review meeting is normally held within 45 working days of our receipt of your request for a second-level appeal.

You or your authorized representative have the right to attend the review meeting for medical necessity appeals, present your position, and ask questions of the committee members present, subject to the rules of procedure established by the committee. If you are unable to appear before the committee, but wish to participate, we will make arrangements for you to participate by means of available technology. For medical necessity appeals, a physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure or treatment under review must agree with any adverse decision made by the committee. The committee will mail its decision regarding either your administrative or medical necessity appeal to you within five working days after the meeting. The committee's decision is final and binding as to any administrative appeal. Medical necessity appeals only can be elevated to the third and final review by an independent external review organization.

Independent External Review

If you still disagree with the medical necessity denial, and have the concurrence of your treating physician, you may request an independent external appeal conducted by a non-affiliated Independent Review Organization (IRO). Within 60 days of receipt of the second-level appeal decision, you should send your written request for an external review to:

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

Requests submitted to us after 60 days of receipt of the denial will not be considered.

We will provide the IRO all pertinent information necessary to conduct the appeal. The IRO decision will be considered a final and binding decision on both the insured and the company. The IRO review will be completed within 72 hours after the appeal is commenced if the request is of an urgent or emergent nature. Otherwise, the review will be completed within 30 days from the receipt of the information from us, unless a longer period is agreed to by the parties. The IRO will notify you or your authorized representative and your health care provider of its decision.

Expedited Internal Appeal

We provide an Expedited Internal Appeal process for review of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize your life, health or ability to regain maximum function. In these cases, we will make a decision no later than 72 hours after the review commences.

An **expedited appeal** is a request concerning an admission, availability of care, continued stay or health care service for a covered person who is requesting emergency services or has received emergency services, but has not been discharged from a facility. Expedited appeals are not provided for review of services previously rendered. An expedited appeal shall be made available to and may be initiated by the covered person or an authorized representative, with the consent of the covered person's treating health care provider, or the provider acting on behalf of the covered person.

Requests for an expedited internal appeal may be oral or written and should be made to:

Blue Cross and Blue Shield of Louisiana
Appeals and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045
1-800-258-3365 or 1-225-291-5370

We must receive proof that your provider supports this request for an expedited internal appeal. In any case where the expedited internal appeal process does not resolve a difference of opinion between us and the covered person or the provider acting on behalf of the covered person, the appeal may be elevated to a second-level standard internal appeal or an expedited external review.

Expedited External Review

An **expedited external review** is a request for immediate review by an IRO of an adverse initial determination not to authorize continued services for members currently in the emergency room, under observation in a facility or receiving inpatient care. Your health care provider must request the expedited external review. Expedited external reviews are not provided for review of services previously rendered. An expedited external review of an adverse decision is available if pursuing the standard appeal procedure could seriously jeopardize your life, health or ability to regain maximum function.

Within 60 days of the denial, the provider should contact our Appeals Coordinator at 1-800-376-7741 or 1-225-293-0625 or send a written request to:

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

We will forward all pertinent information to the IRO so the review is completed no later than 72 hours after the review commences.

Binding Nature of External Review of a Medical Necessity Decision

The process of seeking a medical necessity appeal is set forth above. All external review decisions are binding on us and the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered. This appeals process shall constitute your sole recourse in disputes concerning determinations of whether a health service or item is or was medically necessary.

BLUE*CHOICE 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			
First 60 days	All but $1,100	$0	$1,100 (Part A Deductible)
61st through 90th day	All but $275 a day	$275 a day	$0
91st day and after: — While using 60 lifetime reserve days	All but $550 a day	$550 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.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$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.

BLUE*CHOICE 65* PLAN A

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed $155 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 Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $155 of Medicare-approved amounts*	$0	$0	$155 (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 $155 of Medicare-approved amounts*	$0	$0	$155 (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 HEALTH CARE MEDICARE-APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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 Blue*Choice 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			
First 60 days	All but $1,100	$1,100 (Part A Deductible) **	$0
61st through 90th day	All but $275 a day	$275 a day **	$0
91st day and after: — While using 60 lifetime reserve days	All but $550 a day	$550 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.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$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.

BLUE*CHOICE 65* PLAN B & BLUE*CHOICE 65 SELECT* PLAN B

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed $155 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 Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $155 of Medicare-approved amounts*	$0	$0	$155 (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 $155 of Medicare-approved amounts*	$0	$0	$155 (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 HEALTH CARE MEDICARE-APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

BLUE*CHOICE 65* PLAN F & BLUE*CHOICE 65-SELECT* PLAN F

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 Blue*Choice 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			
First 60 days	All but $1,100	$1,100 (Part A Deductible) **	$0
61st through 90th day	All but $275 a day	$275 a day **	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $550 a day	$550 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.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$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.

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed $155 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 Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $155 of Medicare-approved amounts*	$0	$155 (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 $155 of Medicare-approved amounts*	$0	$155 (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 HEALTH CARE MEDICARE-APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$155 (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

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			
First 60 days	All but $1,100	$1,100 (Part A Deductible)	$0
61st through 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $550 a day	$550 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.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$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 co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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.

BLUE*CHOICE 65* PLAN N & BLUE*CHOICE 65 SELECT* PLAN N (continued)

Medicare (Part B) — Medical Services — Per Calendar Year

* Once you have been billed $155 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 Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $155 of Medicare-approved amounts*	$0	$0	$155 (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 co-payment 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 co-payment 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 $155 of Medicare-approved amounts*	$0	$0	$155 (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 HEALTH CARE MEDICARE-APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment	100%	$0	$0
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan N (continued) 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

N O T E S

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Blue Cross and Blue Shield of Louisiana
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Medicare Customer Service in all other areas: (800) 258-3365

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