BASIC BLUE

STUDENT GROUP HEALTH
INSURANCE BENEFIT PLAN

Louisiana

40HR1611 R07/24

Louisiana

STUDENT GROUP HEALTH
INSURANCE BENEFIT PLAN

NOTICES

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

If You pay the premiums according to the Contract requirements and do not violate any provisions, You may renew this Contract if You choose.

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

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 NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT **WWW.BCBSLA.COM** OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

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 YOUR FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

We base Our payment of Benefits for Your Covered Services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom You receive Covered Services.

Note that federal law prohibits a Non-Network Provider from balance billing You for non-Emergency Medical Services performed at a Network facility unless the Provider issued the required written notice to You and has obtained Your Informed Consent to provide such services.

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

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:

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

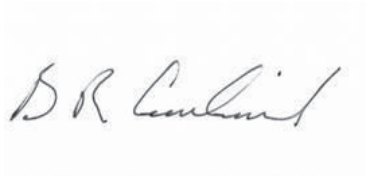
These covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as selected by You in consultation with Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any applicable Copayments, Deductible Amounts and Coinsurances.

Important information regarding this Contract will be sent to the mailing address You provided on the application for coverage. **You are responsible for keeping Us informed of any changes in Your address of record.**

REQUIREMENT TO SELECT A PRIMARY CARE PHYSICIAN (PCP)

This coverage requires You to designate a Primary Care Physician (PCP). You have the right to designate any PCP who participates in your Network and who is available to accept You or Your family members. Until You make this designation, We designate one for You. For children, You may designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of the PCPs in Your Network, visit **www.bcbsla.com** or call the customer service phone number on the ID card. Additional information about Your PCP selection can be found in the Understanding the Basics of Your Coverage Article of this plan.

You do not need prior Authorization from Us or from any other person (including a PCP) in order to obtain direct access to obstetrical or gynecological care from a healthcare professional in Your Network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior Authorization for certain services. For a list of Network healthcare professionals who specialize in obstetrics or gynecology, visit **www.bcbsla.com** or call the customer service phone number on the ID card.



Bryan R. Camerlinck
President and Chief Executive Officer

STUDENT GROUP HEALTH
INSURANCE BENEFIT PLAN

PRESCRIPTION DRUG FORMULARY

NOTICES

NOTICE AND DISCLOSURE OF PRESCRIPTION DRUG FORMULARY

This Benefit Plan covers Prescription Drugs and uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Benefit Plan. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers.

Information about Your formulary is available to You in several ways. Most Members receive information from Us by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy**.

You may also contact Us at the telephone number on the ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on Your Prescription Drug Formulary, this does not guarantee that Your prescribing healthcare Provider will prescribe the drug for a particular medical condition or mental illness.

A closed formulary means that selected Brand-Name Drugs, Generic Drugs, and Specialty Drugs when listed on the formulary are covered. Drugs that are not listed on the closed formulary, also called non-formulary drugs are not covered.

For Prescription Drugs that are not included in Our Prescription Drug Formulary, there is a drug formulary exception process. This process allows You, Your designee or Your prescribing healthcare Provider to ask for a formulary exception from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the request is not approved, You may file an internal or external formulary exception request to Us.

NOTICE OF CONTINUATION OF PRESCRIPTION DRUG COVERAGE

You have the right to continue the coverage of any Prescription Drug that was approved or covered by Us for a medical condition or mental illness, at the contracted Benefit level until the renewal of Your current insurance coverage regardless of whether the drug has been removed from Your formulary. Your prescribing healthcare Provider may prescribe a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug is covered under the health plan and is medically appropriate for You.

BASIC BLUE
STUDENT GROUP HEALTH INSURANCE BENEFIT PLAN
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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

Blue Cross and Blue Shield of Louisiana issues this Student Group Health Insurance Benefit Plan to the University shown on the Schedule of Benefits. A copy of this Benefit Plan provided to Subscribers serves as the Subscriber's certificate of coverage.

As of the Benefit Plan Date shown in the University's Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers of the Group and their enrolled Dependents. This Benefit Plan replaces any others previously issued to the Group as of the Benefit Plan Date or Amended Benefit Plan Date. This Plan describes your Benefits, as well as your rights and responsibilities under the Plan. We encourage you to read this Benefit Plan carefully.

You should call Us if you have questions about your coverage, or any limits to the coverage available to you. Many of the sections of this Benefit Plan are related to other sections of this Plan. You may not have all of the information you need by reading just one section. Please be aware that your Physician does not have a copy of Your Benefit Plan, and is not responsible for knowing or communicating Your Benefits to You.

Except for necessary technical terms, We use common words to describe the Benefits provided under this Benefit Plan. "We," "Us" and "Our" means BLUE CROSS AND BLUE SHIELD OF LOUISIANA. "You," "Your," and "Yourself" means the Subscriber and/or enrolled Dependent. Capitalized words are defined terms in Article II - "Definitions." A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

THIS COVERAGE AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (the Affordable Care Act) were signed into law in March 2010. This coverage is compliant with and subject to the Affordable Care Act and covers all Essential Health Benefits required by law.

A. FACTS ABOUT THIS STUDENT GROUP HEALTH INSURANCE BENEFIT PLAN

This Benefit Plan is a comprehensive blanket group health insurance plan written by Blue Cross and Blue Shield of Louisiana (BCBSLA) and issued to the University. It is a student health insurance policy intended to cover University's Eligible Students and Dependents, as defined in the Benefit Plan. You have an extensive Network of Providers available to You – Blue Cross and Blue Shield of Louisiana's Preferred Care PPO Network (Network). You can also get care from Providers who are not in Your Network, but Benefits will be paid at a lower level of Deductible Amount and Coinsurance.

If you go to Providers in Your Network, You will pay the least for care and get the most value from this Benefit Plan. You choose which Providers will give You care. This choice will determine the amount We pay and the amount the You pay for Covered Services.

If a Copayment is shown on the Schedule of Benefits, You must pay the Copayment to the Network Provider each time You receive the Covered Services listed. Most Benefits are subject to Your payment of a Deductible Amount. After payment of Deductible Amounts, Benefits are subject to 2 Coinsurance (for example, 80/20, 60/40). Your choice of a Provider determines what Coinsurance applies to the service provided. We will pay the highest Coinsurance for Medically Necessary services when You receive care from a Provider in the Preferred Care PPO Network. We will pay the lower Coinsurance when You receive Medically Necessary services from a Provider who is not in the Preferred Care PPO Network. Deductible Amounts and Coinsurance are stated on the Schedule of Benefits.

In order to maximize your student health service Benefits, You should initially visit Louisiana State University Health Science Centers, Student Health Service (LSUHSC) for your Medical care. Some medical services for students are provided as part of your student health fee. If you require health services not available at LSUHSC, You may want to seek care from a PPO Network Provider because Your cost will generally be lower than seeing a Non-Network Provider.

B. OUR PROVIDER NETWORK

Members choose which Providers will render their care. This choice will determine the amount We pay, on behalf of the Group and the amount the Member pays for Covered Services.

Our Preferred Care PPO (or PCare) Network consists of a select group of Physicians, Hospitals and other Allied Health Professionals who have contracted with Us to participate in the Blue Cross and Blue Shield of Louisiana PPO Provider Network and render services to Our Members. We call these Providers "PPO Providers," "Preferred Providers," or "Network Providers." Oral Surgery Benefits are also available when rendered by Providers in United Concordia Dental Advantage Plus Network or in Blue Cross and Blue Shield of Louisiana's dental Network.

To obtain the highest level of Benefits available, the Member should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Care Provider before the service is rendered. Visit Our website at **www.bcbsla.com**, or call customer service at the number on the identification (ID) card to verify that a Provider is a current Network Provider, or to request a paper Provider directory.

A Provider's status may change from time to time. Members should always verify the Network status of a Provider before obtaining services.

A Provider may be contracted with Us when providing services at one location, and may be considered Out-of-Network when rendering services from another location. The Member should make sure to check his Provider directory to verify that the services are In-Network from the location where he is seeking care.

Additionally, Providers in Your network may be contracted to perform certain Covered Services, but may not be contracted in Your network to perform other Covered Services. When a Network Provider performs services that the Network Provider is not contracted with Us to perform (such as certain High-Tech diagnostic or radiology procedures), Claims for those services will be adjudicated at the Non-Network Benefit level. The Member should make sure to check his Provider directory to verify that the services are In-Network when performed by the Provider or at the Provider's location.

C. UNITED CONCORDIA ADVANTAGE PLUS DENTAL NETWORK

Pediatric Dental Care Benefits are covered in this plan for Members under age nineteen (19). United Concordia Companies, Inc. d/b/a United Concordia Dental (hereinafter "UCD") is Blue Cross and Blue Shield of Louisiana's Network and claims administrator for the dental Benefits and is in charge of managing the Advantage Plus Dental Network, handling and paying Claims, and providing customer services to the Members eligible to receive these Benefits.

The Advantage Plus Dental Network (Advantage Plus) consists of a select group of Providers who have contracted with United Concordia Dental to render services to Members for reduced amounts. **All other Providers are considered Non-Participating.** Non-Participating Providers may bill You more for their services than Participating Providers.

In order to receive full pediatric dental Benefits, the Member should verify that a Provider is an Advantage Plus Dental Network Participating Provider before any service is rendered. To locate a Participating Provider and verify their continued participation in the Advantage Plus Dental Network, or to ask any questions related to Benefits or Claims, please visit the website at **www.bcbsla.com**, or contact a customer service representative at (866) 445-5338.

We", "Us" and "Our" means United Concordia Dental when it acts on behalf of Blue Cross and Blue Shield of Louisiana in performing its services under the dental coverage provided for in this Section. Capitalized words are defined terms as described below.

Reimbursements for services rendered by a Non-Participating Provider will be based on Our Allowable Charge and will be paid in the same amounts, under the same limits, rules and policies that We would have applied to Claims for services rendered by a Participating Provider. Care received from a Non-Participating Provider will mean a higher cost to You. We recommend that You ask the Non-Participating Provider about their billed

charges before You receive care.

D. DAVIS VISION NETWORK

Davis Vision, Inc. (hereinafter, "Davis Vision) is the Company's Network and Claims administrator for the Vision Care Benefit provided, and manages the Davis Vision Network, handles and pays Claims, and provides customer services to the Members under age 19 eligible to receive this Benefit.

The Davis Vision Network consists of a select group of Providers who have contracted with Davis Vision to render services to Members for minimal Out-of-Pocket costs. **All other Providers are considered Non-Participating. In order to receive the full Benefit under this section, the Member should verify that a Provider is a Davis Vision Network Participating Provider before any service is rendered.** To locate a Participating Provider and verify their continued participation in the Davis Vision Network, or to ask any questions related to Benefits or Claims, please visit the website at **www.davisvision.com** or contact a customer service representative at 1-800-247-9368.

E. OBTAINING CARE OUTSIDE THE PREFERRED CARE NETWORK

The Preferred Care Network is an extensive Network and should meet the needs of most Members. However, Members choose which Providers will render their care, and Members may obtain care from Providers who are not in Our Preferred Care Network.

We pay, on behalf of the University, a lower level of Benefits when a Member uses a Provider outside the Preferred Care Network. Benefits may be based on a lower Allowable Charge. Care obtained outside Our Network means the Member has higher Out-of-Pocket costs and pays a higher Copayment, Deductible Amount, and/or Coinsurance than if he had stayed in the Network. THESE ADDITIONAL COSTS MAY BE SIGNIFICANT. In addition, the Group only pays a portion of those charges and it is Your responsibility to pay the remainder. To the extent required by applicable law, Your cost sharing for Emergency Medical Services will be at the Network level even if the Hospital is not in Your Network.

We recommend that You ask Non-Network Providers to explain their billed charges to You, BEFORE You receive care outside the Network. You should review the sample illustration below in the section titled "Sample Illustration of Member Costs When Using a Non-Participating Hospital" prior to obtaining care outside the Network.

F. OBTAINING EMERGENCY AND NON-EMERGENCY CARE OUTSIDE LOUISIANA AND AROUND THE WORLD

Members have access to Emergency and non-Emergency care outside Louisiana and around the world. The ID card offers convenient access to Covered Services through Blue Cross and Blue Shield Providers throughout the United States and in more than 200 countries worldwide.

In the United States:

Emergencies: To the extent required by applicable law, Members receive Network Benefits when covered Emergency Medical Services are provided by Providers that are not in Your Network.

Non-Emergencies: Members receive Non-Network Benefits when covered non-Emergency Medical Services are rendered outside the Member's Service Area. Because there is no Preferred Care PPO Network Service Area outside Louisiana, Covered Services rendered outside Louisiana are paid at the Non-Network Benefit level. If a Member obtains these services from a BlueCard® Provider, he may only have to pay his In-Network amount since BlueCard® Providers will generally accept the Allowable Charge as payment in full for the service.

Outside the United States:

Emergencies: To the extent required by applicable law, Members receive Network Benefits when covered Emergency Medical Services are provided by Providers that are not in Your Network.

Non-Emergencies: Members receive Non-Network Benefits when covered non-Emergency Medical Services are rendered outside the Member's Service Area. Because there is no Preferred Care PPO Network Service Area outside the United States, Covered Services rendered outside the country are paid at the Non-Network Benefit level. If a Member obtains these services from a Blue Cross Blue Shield Global® Core Provider, he may only have to pay his Network amount since Blue Cross Blue Shield Global® Core Providers will generally accept the Allowable Charge as payment in full for the service.

How To Get Care Outside the Service Area:

1. In an Emergency, go directly to the nearest Hospital.

2. Call BlueCard® Access at 1-800-810-BLUE (2583) for information on the nearest BlueCard® doctors and Hospitals (for care within the United States), or for information on Blue Cross Blue Shield Global® Core doctors and Hospitals (for care outside the United States). Provider information is also available at **www.bcbs.com**.

3. Use a BlueCard® Nationwide or a Blue Cross Blue Shield Global® Core Provider.

4. Present a Member ID card to the doctor or Hospital, who will verify coverage and file Claims for the Member.

5. The Member must obtain any required Authorizations from Blue Cross and Blue Shield of Louisiana.

G. USING A PRIMARY CARE PHYSICIAN (PCP)

This plan is sold with or without an office visit Copayment. The Schedule of Benefits will state whether a Copayment applies. If a Copayment for office visits is shown on the Schedule of Benefits, this direct access plan allows You to receive care from a Primary Care Physician (PCP) or from a Specialist. No PCP referral is required prior to accessing care directly from a Specialist in the Preferred Care PPO Network.

Members pay the lowest Physician Copayment when obtaining care from a PCP. PCPs are family practitioners, general practitioners, internists, geriatricians, or pediatricians. Each member of the family may use a different PCP. PCPs may coordinate healthcare needs from Consultation to hospitalization, direct a Member to an appropriate Provider when necessary, and assist in obtaining any required Authorizations.

The office visit Copayment may be reduced when services are rendered by a Provider participating in the Quality Blue program. Quality Blue Providers include any Provider who has signed a contract to participate in the Quality Blue program. Currently, Quality Blue Providers include family practitioners, general practitioners, pediatricians, internists, geriatricians, nurse practitioners and physician assistants, but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, You may review a Provider directory on Our website at **www.bcbsla.com** or contact Our customer service department at the number on the ID card.

If one Provider directs a Member to another Provider, the Member must make sure that the new Provider is in the Preferred Care PPO Network before receiving care. If the new Provider is not in the Preferred Care PPO Network, Benefits will be processed at the Non-Network Benefit level and the Allowable Charge applicable to that Provider.

H. AUTHORIZATIONS

Some services and supplies require Authorization from Us before services are obtained. Your Schedule of Benefits lists the services, supplies, and prescription drugs that require this advance Authorization. The list of items and services that require Authorization can also be located on Our website, **www.bcbsla.com/priorauth**.

An Authorization is Our determination that it is Medically Necessary for the Member to receive the requested medical services. When We Authorize a service for Medical Necessity, We are not making a determination about the Member's choice of Provider or the level of Benefits that will apply to a resulting Claim.

Network Providers are required to obtain necessary Authorizations on behalf of the Member. When a Network Provider fails to obtain a required Authorization, We penalize the Network Provider, not the Member, as described on the Schedule of Benefits. The Member continues to be responsible only for the applicable Network Copayment, Deductible Amount, and/or Coinsurance shown on the Schedule of Benefits.

When We issue an Authorization but the Member receives the service from a Non-Preferred Care PPO Network, (a Participating or Non-Participating Provider), Non-Network Benefits will apply, even when We have Authorized the services as Medically Necessary. A Member must obtain care from a Provider in the Preferred Care PPO Network to receive the highest level of Benefits available under this Benefit Plan.

No payment will be made for organ, tissue and bone marrow transplant benefits or evaluations unless We Authorize these services and the services are rendered by a Blue Distinction Center for Transplants (BDCT) for the specific organ or transplant or by a transplant facility in Our Blue Cross and Blue Shield PPO Provider Network, unless otherwise approved by Us in writing. To locate an approved transplant facility, Members should contact Our customer service department at the number listed on the ID card.

I. HOW WE DETERMINE WHAT THE UNIVERSITY PAYS FOR COVERED SERVICES

When the Member uses Network Providers

Network Providers have signed a contract with Us to participate in the PPO Network. These Providers have agreed to accept the lesser of billed charges or an amount negotiated amount as payment in full for Covered Services. This amount is the Network Provider's Allowable Charge and is used to determine the amount We pay for Medically Necessary Covered Services. and the amount that the Member must pay for his Covered Services. Members who use Network Providers will receive Network Benefits and will pay the amounts shown in the Network column on the Schedule of Benefits for these Covered Services.

When the Member uses Participating Providers

Participating Providers have signed a contract with Us or any other Blue Cross and Blue Shield plans to participate in their Provider Networks. These Providers have agreed to accept the lesser of billed charges or a negotiated amount as payment in full for Covered Services. This amount is the Participating Provider's Allowable Charge and is used to determine the amount We pay for Medically Necessary Covered Services.

Members who use a Participating Provider will pay more for Medically Necessary Covered Services than if a PPO Network Provider was used. This will result in higher costs to the Member as shown in the Non-Network column on the Schedule of Benefits. However, the Member will be protected from paying the difference between the Allowable Charge and the Provider's billed charge.

The Member has the right to file an Appeal with Us for consideration of Network Benefits if the Member received Covered Services from a Participating Provider who was the only Provider available to deliver the Covered Service within a 75-mile radius of the Member's home. To file an Appeal, the Member must follow the Appeal procedures in this Contract.

When the Member uses Non-Participating Providers

Non-Participating Providers do not have a contract with the HMOLA Network, with Blue Cross and Blue Shield of Louisiana, or any other Blue Cross and Blue Shield plans. These Providers are not in Our Networks. We

have no fee arrangements with them. We establish an Allowable Charge for Covered Services provided by Non-Participating Providers.

The Allowable Charge will be We use the lesser of the following:

1. an amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;

2. an amount We establish as the Allowable Charge; or

3. the Provider's billed charge. You will receive a lower level of Benefit because You did not go to a Network Provider.

Members usually pay significant costs when using Non-Participating Providers. This is because the amounts that some Providers charge for Covered Services may be higher than the established Allowable Charge. Also, Network Providers and Participating Providers waive the difference between the actual billed charge for Covered Services and the Allowable Charge, while Non-Participating Providers do not.

The Member has the right to file an Appeal with Us for consideration of Network Benefits if the Member received Covered Services from a Non-Participating Provider who was the only Provider available to deliver the Covered Service within a 75-mile radius of the Member's home. To file an Appeal, the Member must follow the Appeal procedures set forth in this Benefit Plan.

Note that federal law prohibits a Non-Network Provider from balance billing a Member for non-Emergency Medical Services performed at a Network facility unless the Provider issued the required written notice to a Member and has obtained a Member's Informed Consent to provide such services.

J. SAMPLE ILLUSTRATION OF MEMBER COSTS WHEN USING A NON-PARTICIPATING HOSPITAL

NOTE: The following example is for illustration purposes only and may not be a true reflection of the Member's actual Copayments, Deductible Amount and Coinsurance. Please refer to the Schedule of Benefits to determine Your Benefits.

EXAMPLE: A Member has this plan with a $350 per diem for the first three (3) days of hospital admission. The Non-Network Benefits are 70% - 30% Coinsurance with a Deductible Amount. Assume the Member goes to the Hospital, has previously met his Deductible Amount, and has obtained the necessary Authorization prior to receiving a non-Emergency service. The Hospital bills $12,000 for the Covered Service. We negotiated an Allowable Charge of $2,500 with the Network Hospital to render this service. The Allowable Charge of the Participating Hospital is $3,500 to render this service. There is no negotiated rate with the Non-Participating Provider Hospital. The Member is responsible for all amounts not paid by the Company, up to the Hospital's billed charge. This example illustrates the Member's costs at three different hospitals for the same service.

	Network Providers	**Non-Network Providers**	
The Member receives Covered Services from:	**Network Hospital**	**Participating Hospital**	**Non-Participating Hospital**
Hospital Bill:	$12,000	$12,000	$12,000
Allowable Charge:	$2,500	$3,500	$2,500

We pay:	**$2,500** $2,500 Allowable Charge x 100% Coinsurance = $2,500	**$2,100** $3,500 Allowable Charge x 70% Coinsurance = $2,450	**$1,750** $2,500 Allowable Charge x 70% Coinsurance = $1,750
Member pays:	**$350** per diem x 3 days of admission + 0% Coinsurance x $2500 Allowable Charge = $0	**$1,050** 30% Coinsurance x $3,500 Allowable Charge = $1,050	**$750** $2,500 Allowable Charge x 30% Coinsurance = $750
Is Member billed up to the Hospital's billed charge?	NO	NO	YES $9,500
TOTAL AMOUNT MEMBER PAYS:	**$1,050**	**$1,050**	**$10,250**

K. WHEN A MEMBER PURCHASES COVERED PRESCRIPTION DRUGS

Some pharmacies have contracted with the Company or with its Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount We pay Our Pharmacy Benefit Manager to base the Company's payment for a Member's covered Prescription Drugs and the amount that the Member must pay for his covered Prescription Drugs and the amount that the Member must pay for covered Prescription Drugs.

When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with the Company or with Our Pharmacy Benefit Manager or when a Member files a paper Claim with the Company or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that the Company pays Our Pharmacy Benefit Manager for covered Prescription Drugs.

To obtain contact information for "Participating Pharmacies", the Member should contact Our customer service department or Our Pharmacy Benefit Manager at the telephone number on the ID card.

L. MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

The Company has contracted with an outside company to perform certain administrative services related to Mental Health and substance use disorder Benefits for Members. For help with these Benefits, the Member should refer to the Schedule of Benefits, the ID card, or call Our customer service department.

M. ASSIGNMENT

1. A Member's rights and Benefits under this Benefit Plan are personal to the Member and may not be assigned in whole or in part by the Member. We will recognize assignments of Benefits to Hospitals if both this Benefit Plan

and the Provider are subject to La. R.S. 40:2010. If both this Benefit Plan and the Provider are not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the health plan or Us liable to any third-party to whom a Member may be liable for the cost of medical care, treatment, or services.

2. We reserve the right to pay, on behalf of the University, PPO and Participating Providers directly instead of paying the Member.

N. MEMBER INCENTIVES AND VALUE-ADDED SERVICES

Sometimes We may offer Members coupons, discounts, and incentives to enroll in programs, such as pharmacy programs, disease management programs, and wellness programs and activities. We may offer Members discounts or financial incentives to use certain Providers for selected Covered Services. We may also offer Members the opportunity to enroll in health and non-health related programs, as value-added services, to enhance the Member's experience with Us or his Providers. These incentives and value-added services are not Benefits and do not alter or affect Member Benefits. They may be offered by Us, affiliated companies, and selected vendors. Members are always free to reject the opportunities for incentives and value-added services. We reserve the right to add or remove any and all coupons, discounts, incentives, programs, and value-added services at any time without notice to Members.

O. HEALTH MANAGEMENT AND WELLNESS TOOLS AND RESOURCES

We offer Members a wide range of health management and wellness tools and resources. Members can use these tools to manage their personal accounts, see Claims history, create health records and access a host of online wellness interactive tools. Members also have access to a comprehensive wellness program that includes a personal health assessment and customized health report to assess health risks based on his history and habits. Exclusive discounts are also available to Members on some health services such as fitness club memberships, diet and weight control programs, vision and hearing care and more.

P. CUSTOMER SERVICE E-MAIL ADDRESS

Blue Cross and Blue Shield of Louisiana has consolidated its customer service e-mails into a single, easy-to-remember address: **help@bcbsla.com**. Customers who need to contact Us may find all of their options online, including phone, fax, e-mail, postal mail and walk-in customer service. Just visit **www.bcbsla.com** and click on *Need Help?* To access our Help Center which includes Our customer service contact information.

Q. IDENTITY PROTECTION SERVICES

Blue Cross and Blue Shield of Louisiana is committed to identity protection for its covered Members. This includes protecting the safety and security of Members' information. To support the Company's efforts, Blue Cross and Blue Shield of Louisiana offers optional Identity Protection Services. If Identity Protection Services are elected, the services will include the following:

1. Credit monitoring which monitors activity that may affect credit.
2. Fraud detection which identifies potentially fraudulent use of identity or credit.
3. Fraud resolution support that assists Members in addressing issues that arise in relation to credit monitoring and fraud detection.

A Member ceases to be eligible for these services if health coverage is terminated during the Plan Year. If health coverage is terminated during the Plan Year, Identity Protection Services will be provided to the Member through the end of the Plan Year.

Information about Identity Protection Services can be found at **www.bcbsla.com** or by calling the customer service telephone number on the ID card.

ARTICLE II. DEFINITIONS

Accidental Injury – A condition, which is a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, injuries caused by the act of chewing do not constitute an injury caused by external force.

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

Adverse Benefit Determination – Means denial or partial denial of a Benefit based on:

A. Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment that is determined to be experimental or investigational;

B. the Member's eligibility for coverage under the Benefit Plan;

C. any prospective or retrospective review determination;

D. a Rescission; or

E. a decision involving items and services within the scope of the surprise billing and cost-sharing protection requirements of the No Surprises Act.

Allied Health Facility – An institution, other than a Hospital, licensed by the appropriate state agency where required, and/or approved by Us to render Covered Services.

Allied Health Professional – A person or entity other than a Hospital, Doctor of Medicine, or Doctor of Osteopathy who is licensed by the appropriate state agency, where required, and/or approved by Us to render Covered Services. For coverage purposes under this Benefit Plan, Allied Health Professional includes dentists, psychologists, Retail Health Clinics, certified midwives, registered Doulas, certified nurse practitioners, optometrists, pharmacists, chiropractors, podiatrists, physician assistants, registered nurse first assistant, advanced practice registered nurse, licensed professional counselors, licensed clinical social workers, certified registered nurse anesthetists, and any other health professional as mandated by state law for specified services, if approved by Us to render Covered Services.

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

Allowable Charge –

A. For Preferred Providers and Participating Providers – The lesser of the billed charge or the amount We establish or negotiate as the maximum amount allowed for services from these all Providers services covered under the terms of this Contract.

B. For Non-Participating Providers – The lesser of:

    1. An amount We establish based on Our choice of Medicare's published fee schedule, what Medicare pays, or what Medicare allows for the service;
    2. an amount We establish as the Allowable Charge; or
    3. the Provider's billed charge.

Alternative Benefits – Benefits for services not routinely covered under this Benefit Plan but which the Company may agree to provide when it is beneficial both to the Member and to Us.

Ambulance Service – Medically Necessary transportation by a specially designed Emergency vehicle for transporting the sick and injured. The vehicle must be equipped as an Emergency transport vehicle and staffed by trained ambulance personnel as required by appropriate State and local laws governing an Emergency transportation vehicle.

Ambulatory Surgical Center – An Allied Health Facility Provider that is established with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center; 1) Anesthesia services as needed for medical operations and procedures performed; 2) Provisions for physical and emotional well-being of patients; 3) Provision for Emergency services; 4) Organized administrative structure; and 5) Administrative, statistical and medical records.

Appeal – A written request from the Member or a Member's authorized representative to change an Adverse Benefit Determination made by Us.

Applied Behavior Analysis (ABA) – The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Providers of ABA shall be certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior Analyst Certification Board or the appropriate licensing agency, if within another state.

Authorization (Authorized) – A determination by the Company regarding an Admission, continued Hospital stay, or other healthcare service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the healthcare setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Member's choice of Provider.

Autism Spectrum Disorders (ASD) – Any of the pervasive development disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM). These disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. ASD includes conditions such as Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified.

Bed, Board and General Nursing Service – Room accommodations, meals and all general services and activities provided by a Hospital employee for the care of a patient. This includes all nursing care and nursing instructional services provided as a part of the Hospital's bed and board charge.

Benefits – Coverage for healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies provided under this Benefit Plan. We base the payment for Benefits on the Allowable Charge for Covered Services.

Benefit Plan – This agreement, including any Applications for Coverage, Schedule of Benefits and amendments/endorsements to this agreement, if any, entitling the University's Subscribers and their Dependents to Benefits.

Benefit Plan Date – The date upon which We issued this Benefit Plan to the University.

Bone Mass Measurement – A radiologic or radioisotopic procedure or other scientifically proven technologies performed on an individual for the purpose of identifying bone mass or detecting bone loss.

Brand-Name Drug – A Prescription Drug that is a patented drug marketed by the original drug manufacturer following its Food and Drug Administration (FDA) approval, or that We identify as a Brand-Name product. We classify a prescription drug as a Brand-Name Drug based on a nationally recognized pricing source, therefore all products identified as a "Brand-Name" by the manufacturer or pharmacy may not be classified as a Brand-Name Drug by Us.

Cardiac Rehabilitation – A structured program that provides coordinated, multi-faceted interventions including supervised exercise training, education, counseling and other secondary prevention interventions. It is designed to speed recovery from acute cardiovascular events such as myocardial infarction, myocardial revascularization, or hospitalization for heart failure and to improve functional and psychosocial capabilities.

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

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

Case Management – Case Management is a method of delivering patient care that emphasizes quality patient outcomes with efficient and cost-effective care. The process of Case Management systematically identifies high-risk patients and assesses opportunities to coordinate and manage patients' total care to ensure the optimal health outcomes. Case Management is a service offered at Our option administered by medical professionals, which focuses on unusually complex, difficult or catastrophic illnesses. Working with the Member's Physician(s) and subject to the Member's consent and/or the Member's family/caregiver, the Case Management staff will manage care to achieve the most efficient and effective use of resources.

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

Chiropractic Services – The diagnosing of conditions associated with the functional integrity of the spine and the treatment of such conditions by adjustment, manipulation, and the use of physical and other properties of heat, light, water, electricity, sound, massage, therapeutic exercise, mobilization, mechanical devices such as mechanical traction and mechanical massage, and other rehabilitative measures for the purpose of correcting interference with normal nerve transmission and expression.

Claim – A Claim is written or electronic proof, in a form acceptable to Us, of charges for Covered Services that have been incurred by the Member during the time-period the Member was insured under this Benefit Plan. The provisions in effect at the time the service or treatment is received shall govern the processing of any Claim expense actually incurred as a result of the service or treatment rendered.

Cleft Lip and Cleft Palate Services – Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and its regulations.

Coinsurance – The sharing of Allowable Charges for Covered Services. The sharing is expressed as a pair of percentages, a Company percentage that We pay, and a Member percentage that You pay. Once the Member has met any applicable Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Covered Services to determine the Member's financial responsibility. Our percentage will be applied to the Allowable Charges for Covered Services to determine the Benefits provided.

Company – Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company).

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

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

Concurrent Care – Hospital Inpatient medical and surgical care by a Physician, other than the attending Physician: (1) for a condition not related to the primary diagnosis or, (2) because the medical complexity of the patient's condition requires additional medical care.

Concurrent Review – A review of Medical Necessity, appropriateness of care, or level of care conducted during a patient's Inpatient facility stay or course of treatment.

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

Consultation – Another Physician's opinion or advice as to the Member's evaluation or treatment, which is furnished upon the request of the attending Physician. These services are not intended to include those Consultations required by Hospital rules and regulations, anesthesia Consultations, routine Consultations for clearance for Surgery, or Consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge.

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

Copayment (Copay) – The specific dollar amount a Member must pay when specified Covered Services are rendered, as shown on the Schedule of Benefits. The Copayment may be collected directly from a Member by a Network Provider.

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

Covered Service – A service or supply specified in this Benefit Plan for which Benefits are available when rendered by a Provider.

Creditable Coverage for HIPAA Portability – Prior coverage under an individual or group health plan including, but not limited to, Medicare, Medicaid, government plan, church plan, COBRA, military plan or state children's health insurance program (e.g., LaCHIP). Creditable coverage does not include specific disease policies (i.e., cancer policies), supplemental coverage (i.e., Medicare Supplement) or limited Benefits (i.e., accident only, disability insurance, liability insurance, workers' compensation, automobile medical payment insurance, credit only insurance; coverage for on-site medical clinics or coverage as specified in federal regulations under which Benefits for medical care are secondary or incidental to the insurance Benefits).

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

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

We determine services are Custodial Care.

Day Rehabilitation Program – A program that provides greater than one (1) hour of Rehabilitative Care, upon discharge from an Inpatient Admission.

Deductible Amounts –

A. Plan Year Deductible Amount

1. The dollar amount, as shown on the Schedule of Benefits, of charges for Covered Services that a Member must pay within a Plan Year before Benefits are provided.

2. Network and Non-Network Benefit categories may each carry a separate Plan Year Deductible Amount as shown on the Schedule of Benefits.

B. Family Deductible Amount

1. If shown on the Schedule of Benefits, is the amount shown for each category of Benefits to which a Deductible Amount applies. Once a family has met its Family Deductible Amount, this Benefit Plan starts paying Benefits for all members of the family, regardless of whether each individual has met his individual amount.

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

A. represents himself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;

B. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a filling, crown, denture, or other appliance; or

C. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair prosthetic dentures, bridges, or other substitute for natural teeth to the user or prospective user.

Dependent – A person, other than the Subscriber, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

Diagnostic Service – Radiology, laboratory, and pathology services and other tests or procedures We recognize as accepted medical practice, rendered because of specific symptoms, and which are directed toward detection or monitoring of a definite condition, illness or injury. A Diagnostic Service must be ordered by a Provider prior to delivery of the service.

Doula – An individual who has an approved registration through the Louisiana Doula Registry Board, has met Our credentialing standards, and who is trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families before, during, and after childbirth.

Durable Medical Equipment – Items and supplies which are used to serve a specific therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home.

Effective Date – The date when a Member's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 AM on this date.

Elective Admission – Any Inpatient Hospital Admission, whether it be for medical or Surgical care, for which a reasonable delay will not unfavorably affect the outcome of the treatment.

Eligible Student – A registered student, Fellow or Post-Doctoral Fellow, Domestic or International student who is enrolled in a Participating College/Program and is physically and actively attending classes for at least thirty-one (31) days after the effective date of coverage under this Benefit Plan. When an Eligible Student actually enrolls, we refer to that person as a Subscriber.

Eligible Person – A person entitled to apply to be a Subscriber or a Dependent as specified in the Schedule of Eligibility.

Eligibility Waiting Period – The period that must pass before an individual's coverage can become effective for Benefits under this Benefit Plan. If an individual enrolls as a Special Enrollee, any period before such Special Enrollment is not an Eligibility Waiting Period.

Emergency – See “Emergency Medical Condition.”

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

Emergency Medical Condition (Emergency) – A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the person , or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; 2) serious impairment to bodily function; or 3) serious dysfunction of any bodily organ or part.

Emergency Medical Services – The following when related to an Emergency Medical Condition, unless not required by applicable law:

A. When within the capability of a Hospital or independent freestanding emergency department, the following services and items:

    1. A medical screening examination, including ancillary services routinely available to the Emergency department to evaluate an Emergency Medical Condition.

    2. Further medical examination and such treatment as may be required to stabilize the medical condition, regardless of the department of the Hospital in which such further examination or treatment is furnished.

B. With respect to an Emergency Medical Condition and regardless of the department of the Hospital where furnished, additional services that are:

    1. Covered Services under the [Contract / Policy];

    2. Furnished after the Member is stabilized; and

    3. Part of an Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Medical Services are furnished.

    If certain conditions set forth in applicable law are met, the additional services listed above are not deemed to be Emergency Medical Services and are not required to be covered as Emergency Medical Services.

Enrollment Date – The first day of coverage under this Benefit Plan or, if there is an Eligibility Waiting Period, the first day of the Eligibility Waiting Period.

Essential Health Benefits – Benefits required to be covered by this policy under the Patient Protection and Affordable Care Act, which include at least the following ten general categories: ambulatory patient services; Emergency Medical Services; hospitalization; maternity and newborn care; Mental Health and substance use disorder services, including behavioral health treatment; Prescription Drugs; Rehabilitative and habilitative services and devices; laboratory services; Preventive or Wellness Care services and chronic disease management; pediatric services, including oral and vision care.

Expedited Appeal – A request for immediate internal review of an Adverse Benefit Determination which involves any of the following situations:

A. A medical condition for which the time frame for completion of a standard Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member’s ability to regain maximum function.

B. In the opinion of the treating Physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision.

C. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

Expedited External Appeal – A request for immediate review, by an Independent Review Organization (IRO), of an initial Adverse Benefit Determination, which involves any of the following:

A. A medical condition for which the time frame for completion of a standard External Appeal would seriously jeopardize the life or health of the Member or jeopardize the Member's ability to regain maximum function.

B. A decision to not Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

C. A denial of coverage based on a determination that the recommended or requested healthcare service or treatment is experimental or Investigational and the treating Physician certifies that any delay may pose an imminent threat to the Member's health, including severe pain, potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the health of the Member.

External Appeal – A request for review by an Independent Review Organization to change an initial Adverse Benefit Determination made by the Company or to change a final Adverse Benefit Determination rendered on Appeal. An External Appeal is available upon request by the Member or the Member's authorized representative for Adverse Determinations involving Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness, experimental or Investigational treatment, Rescission, or for Claims for which external review is provided under the No Surprises Act.

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

Generic Drug – A Prescription Drug that is equivalent to a Brand-Name Drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use; or that We identify as a Generic Drug. Classification of a Prescription Drug as a Generic Drug is determined by Us and not by the manufacturer or pharmacy. We classify a Prescription Drug as a Generic Drug based on a nationally recognized pricing source; therefore, all products identified as a "Generic" by the manufacturer or a pharmacy may not be classified as a Generic by Us.

Gestational Carrier – A woman, not covered on the Plan, who agrees to engage in a process by which she attempts to carry and give birth to a child born as the result of an in utero transfer of a human embryo to which she makes no genetic contribution.

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

Group – LOUISIANA STATE UNIVERSITY HEALTH SCIENCE CENTERS STUDENT HEALTH SERVICE (LSUHSC), which has made application for coverage herein and has agreed to comply with all the terms and requirements of this Benefit Plan. For purposes of this Benefit Plan, the University is the policyholder.

Habilitative Care – Healthcare services and devices that help a person keep, learn or improve skills and functioning for daily living. These services may include Physical Therapy, Occupational Therapy, Speech-Language Pathology, Cardiac Rehabilitation, Pulmonary Rehabilitation and other services for people with disabilities in a variety of inpatient and/or Outpatient settings.

Home Health Care – Health services rendered in the individual's place of residence by an organization licensed as a Home Health Care agency by the appropriate state agency and that We approve. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse (RN) licensed to practice in the state.

Hospice Care – Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Members and their families during the final stages of terminal illness. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency that We approve.

Hospital – An institution that is licensed by the appropriate state agency as a general medical surgical Hospital. The term Hospital may also include an institution that primarily provides psychiatric, chemical dependency, rehabilitation, skilled nursing, long term, intermediate care, or other specialty care.

Imaging Services –

A. Low-Tech Imaging – Imaging Services which include, but are not limited to, x-rays, machine tests, diagnostic imaging, and radiation therapy.

B. High-Tech Imaging – Imaging Services which include, but are not limited to, MRIs, MRAs, CT Scans, PET Scans, and nuclear cardiology.

Implantable Medical Devices – A medical device that is surgically implanted in the body, is not reusable, and can be removed.

Independent Review Organization (IRO) – An entity, not affiliated with Us, that conducts external reviews of Adverse Benefit Determinations, Rescission determinations and No Surprises Act-related decisions. The decision of the IRO is binding on both Members and Us, except to the extent that other remedies are available under state or federal law.

Initial Enrollment Period – The initial period of time, as We agree with the University, during which Eligible Students may enroll themselves and their Dependents under the Benefit Plan. Coverage begins on the Effective Date identified in the Benefit Plan if We receive the completed enrollment form and any required premium within thirty (30) days of the Effective Date.

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

Informal Reconsideration – A request by telephone for additional review of a Utilization Management determination not to authorize. Informal reconsideration is available only for initial or Concurrent Review determinations that are requested within ten (10) days of denial.

Informed Consent – A written document provided along with a written notice to a Member by a Non-Network Provider that must be executed by a Member in order for a Non-Network Provider to obtain the Member's consent to receive medical treatment and services from the Non-Network Provider without the protections provided by the No Surprises Act.

Inpatient – A Member who is a registered bed patient for whom a Bed, Board and General Nursing Service charge is made. An Inpatient's medical symptoms or condition must require continuous twenty-four (24) hour a day Physician and nursing intervention. If the services can be safely provided to the Member as an Outpatient, the Member does not meet the criteria for an Inpatient.

Intensive Outpatient Programs – An Outpatient treatment programs that provides a planned and structured, intensive level of care of at least two (2) hours per day and three (3) days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a Mental Disorder and/or a substance use disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment, rehabilitation, counseling visits or professional supervision and support. Program models include structured crisis intervention programs, psychiatric or psychosocial rehabilitation, and some day treatment. Although treatment for substance use disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge.

Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination We make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

    1. consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other non-affiliated technology evaluation center(s);

    2. credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or

    3. reference to federal regulations.

Iatrogenic Infertility – Impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other Medically Necessary medical treatment affecting the reproductive organs or processes.

Life-Threatening Illness – A severe, serious, or acute condition for which death is probable.

Medically Necessary (Medical Necessity) – Healthcare services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. in accordance with nationally accepted standards of medical practice;

B. clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

C. not primarily for the personal comfort or convenience of the patient or Provider, and not more costly than alternative services, treatment, procedures, equipment, drugs, devices, items or supplies or sequence thereof and that are as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member – A Subscriber or an enrolled Dependent.

Mental Disorder (Mental Health) – A clinically significant behavioral and psychological syndrome or pattern. This includes, but is not limited to:

A. psychoses,
B. neurotic disorders,
C. personality disorders,
D. affective disorders,

The specific severe mental illnesses defined by La. R.S. 22:1043:

E. schizophrenia or schizoaffective disorder;
F. bipolar disorder;
G. panic disorder;
H. obsessive-compulsive disorder;
I. major depressive disorder;
J. anorexia/bulimia;

K. intermittent explosive disorder;
L. post-traumatic stress disorder;
M. psychosis NOS when diagnosed in a child under seventeen (17) years of age;
N. Rett's Disorder;
O. Tourette's Disorder); and
P. conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including other non-psychotic mental disorders, to be determined by the Company.

The definition of Mental Disorder (Mental Health) is the basis for determining Benefits, despite whether the conditions are genetic, organic, chemical or biological, regardless of cause or other medical conditions.

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

Network Benefits – Benefits for care received from a Preferred Care PPO Network Provider.

Network Pharmacy – A pharmacy contracted with Us or Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for covered Prescription Drugs they dispense to Members. Network Pharmacies may also be referred to as Participating Pharmacies.

Network Provider – A Provider that has signed an agreement with Us or another Blue Cross and Blue Shield Plan to participate as a member of the Preferred Care Provider Network or another PPO Network. This Provider may also be referred to as a Preferred Provider or In-Network Provider.

Newly Born Infant – An infant from the time of birth until age one month or until such time as the infant is well enough to be discharged from a Hospital or neonatal Special Care Unit to his home, whichever period is longer.

No Surprises Act (NSA) – A portion of the Consolidated Appropriations Act, 2021 (Public Law 116-260) enacted on December 27, 2020, that establishes patient rights and protections from surprise billing and limits cost sharing under many of the circumstances in which surprise billing occurs most frequently.

Non-Network Benefits – Benefits for care received from Non-Network Providers.

Non-Network Provider – A Provider who is not a member of Our Preferred Care Provider Network or another Blue Cross and Blue Shield Plan PPO Network. Participating Providers and Non-Participating Providers are Non-Network Providers.

Occupational Therapy (OT) – The evaluation and treatment of physical injury or disease, cognitive impairments, congenital or developmental disabilities, or the aging process by the use of specific goal directed activities, therapeutic exercises and/or other interventions that alleviate an impairment and/or improve functional performance. These can include the design, fabrication or application of orthotic devices; training in the use of orthotic and prosthetic devices; design, development, adaptation or training in the use of assistive devices; and the adaptation of environments to enhance functional performance.

Open Enrollment Period – A period of time, designated by the University, during which a Subscriber and their eligible Dependents may enroll for Benefits under this Benefit Plan.

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

Out-of-Pocket Amount – The maximum amount, as shown on the Schedule of Benefits, of unreimbursable expenses which must be paid by a Member for Covered Services in one Plan Year.

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

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

Partial Hospitalization Programs – Programs that provide structured and medically supervised day, evening and/or night treatment programs for at least four (4) hours per day and three (3) days per week, although some patients may need to attend less often. The services are of essentially the same nature and intensity (including medical and nursing) as those provided in a Hospital except that patients are in the program less than twenty-four (24) hours per day. Patients are not considered residents at the program. The range of services offered is designed to address a Mental Health and/or substance use disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

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

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

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

Plan Year – A period of time beginning with the Effective Date of this Benefit Plan or the anniversary of this date and ending on the day before the next anniversary of the Effective Date of this Benefit Plan.

Pregnancy Care – Treatment or services related to all care prior to delivery, delivery, post-delivery care, and any Complications arising from each pregnancy.

Prescription Drugs – Medications, which includes Specialty Drugs, the sale or dispensing of which legally requires the order of a Physician or other healthcare professional and that carry the federally required product legend stipulating that such drugs may not be dispensed without a prescription, and which are currently approved by the FDA for safety and effectiveness, subject to the Limitations and Exclusions Article.

Prescription Drug Coinsurance – The sharing of Allowable Charges for Prescription Drugs. The sharing is expressed as a pair of percentages; a Company percentage that We pay and a Member percentage that You pay. Once the Member has met any applicable Prescription Drug Deductible Amount, the Member's percentage will be applied to the Allowable Charges for Prescription Drugs to determine the Member's financial responsibility. Our percentage will be applied to the Allowable Charges for Prescription Drugs to determine the Benefits provided. A different Prescription Drug Coinsurance may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

Prescription Drug Copayment – The amount a Member must pay for each prescription at a participating pharmacy at the time a prescription is filled. A different Copayment may be required for the different drug tiers purchased at a retail pharmacy or through the mail.

Prescription Drug Formulary – A list of specific Prescription Drugs that are covered under this insurance policy.

Preventive or Wellness Care – Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

Primary Care Physician (PCP) – A Physician who is a family practitioner, general practitioner, internist, geriatrician or pediatrician. When performing primary care services, a nurse practitioner and a physician assistant may be treated as a PCP

Private Duty Nursing Services – Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is unrelated to the patient by blood, marriage or adoption. These services must be ordered by the attending Physician and require the technical skills of an RN or LPN. We determine which services are Private Duty Nursing Services. Private Duty Nursing Services that are determined by Us to be Custodial Care are not covered.

Prosthetic Appliance or Device – Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part. When referring to limb prostheses, it is an artificial limb designed to maximize function, stability, and safety of the patient, that is not surgically implanted and that is used to replace a missing limb. Limb Prosthetics do not include artificial eyes, ears, nose, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services – The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. Also includes medically necessary clinical care.

Provider – A Hospital, Allied Health Facility, Physician, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by Us. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

A. Preferred Provider – A Provider who has entered into a contract with Us or another Blue Cross and Blue Shield plan to participate in Our Preferred Care Preferred Provider Organization (PPO Network). We call these Providers "PPO Providers," "Preferred Providers," or "Network Providers."

B. Participating Provider – A Provider that has a signed contract with Us or HMO Louisiana, Inc. or another Blue Cross and Blue Shield plan, for other than Our Preferred Care or Preferred Provider Organization (PPO) Network, or has a signed contract with another Blue Cross and Blue Shield plan to participate in its Provider Networks. These are Non-Network Providers.

C. Non-Participating Provider – A Provider that does not have a signed contract with Us, HMO Louisiana, Inc., or another Blue Cross and Blue Shield plan. These are Non-Network Providers.

D. Quality Blue Primary Care Provider – Any Provider who has signed a contract to participate in the Quality Blue program. Currently, Quality Blue Providers include family practitioners, general practitioners, pediatricians, internists, geriatricians, nurse practitioners and physician assistants, but more Providers may contract to participate in the Quality Blue program. To verify if a Provider participates in the Quality Blue program, You may review a Provider directory on Our website at **www.bcbsla.com** or contact Our customer service department at the number on the ID card.

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

Pulmonary Rehabilitation – A comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.

Rehabilitative Care – Healthcare services and devices that help a person keep, resume or improve skills and functioning for daily living that have been lost or impaired because a patient was sick, hurt or disabled. These services may include Physical Therapy, Occupational Therapy, Speech-Language Pathology, Cardiac

Rehabilitation, Pulmonary Rehabilitation and psychiatric rehabilitation services in a variety of inpatient and/or Outpatient settings.

Remote Patient Therapy Services – A mode of delivering healthcare services that involves the collection of and electronic transmission of biometric data that are analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. Remote Patient Therapy Services must be ordered by a licensed Physician, physician assistant, advanced practice registered nurse, or other qualified healthcare Provider who has examined the patient and with whom the patient has an established, documented, and ongoing relationship.

Repatriation – The act of returning to the country of birth, citizenship or origin.

Rescission – Cancellation or discontinuance of coverage that has retroactive effect. This includes a cancellation that treats a policy as void from the time of enrollment or a cancellation that voids Benefits paid up to one year before the cancellation.

Residential Treatment Center – A twenty-four (24) hour, non-acute care treatment setting for the active treatment of specific impairments of Mental Health or substance use disorder.

Retail Health Clinic – A non-Emergency medical health clinic providing limited primary care services and operating generally in retail stores and outlets.

Serious and Complex Condition – As used in the context of continuity of healthcare services, this term means:

A. For an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

B. For a chronic illness or condition, a condition that is:

    1. life-threatening, degenerative, potentially disabling, or congenital; and

    2. requires specialized medical care over a prolonged period of time.

Skilled Nursing Facility or Unit – A facility licensed by the state in which it operates and is other than a nursing home, or a unit within a Hospital (unless skilled nursing in the nursing home or unit within a Hospital was specifically approved by Us), that provides:

A. Inpatient medical care, treatment and skilled nursing care as defined by Medicare and which meets the Medicare requirements for this type of facility;

B. full-time supervision by at least one Physician or Registered Nurse;

C. twenty-four (24) hour nursing service by Registered Nurses or Licensed Practical Nurses; and

D. Utilization review plans for all patients.

Serious Acute Condition – A disease or condition requiring complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.

Special Care Unit – A designated Hospital unit which We approve and which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, such as an intermediate care neonatal unit, telemetry unit for heart patients, or an isolation unit.

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Benefit Plan) within sixty (60) days of losing other certain health coverage or acquiring a new Dependent as a result of marriage, birth, adoption or placement of adoption.

Specialist – A Physician who is not practicing in the capacity of a Primary Care Physician.

Specialty Drugs – Specialty Drugs are typically high in cost and have one or more of the following characteristics:

A. Specialized patient training on the administration of the drug (including supplies and devices needed for administration) is required.

B. Coordination of care is required prior to drug therapy initiation and/or during therapy.

C. Unique patient compliance and safety monitoring requirements.

D. Unique requirements for handling, shipping and storage.

E. Restricted access or limited distribution.

Specialty drugs also include biosimilars. Biosimilars are drugs that are similar to currently marketed Brand-Name drugs, but do not have the exact same active ingredient. Biosimilars are not considered Generic Drugs.

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

Spouse – The Subscriber's legal Spouse.

Subscriber – An Eligible Student who is properly enrolled under the Benefit Plan. The Subscriber is the person (who is not a Dependent) on whose behalf the Benefit Plan is issued to the University.

Surgery –

A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, incisional and excisional biopsies and other invasive procedures.

B. The correction of fractures and dislocations.

C. Pregnancy Care to include vaginal deliveries and cesarean sections.

D. Usual and related pre-operative and post-operative care.

E. Other procedures that We define and approve.

Telehealth Services – A mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, self-management of patients, and caregiver support at a distance from healthcare Providers approved by Us to render Telehealth Services. Telehealth Services give Providers the ability to render services when the Provider and patient are in separate locations.

A. Asynchronous Telehealth Services – the transmission of a patient's pre-recorded medical information from an originating site to the Provider at a distant site without the patient being present.

B. Synchronous Telehealth Services – the interaction between patient and Provider in different locations in real time, by means of two-way video and audio transmission, usually through an established patient portal.

Temporarily Medically-Disabled Mother – A woman who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

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

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

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

Utilization Management – Evaluation of necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities.

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

Waiting Period – see "Eligibility Waiting Period."

Well Baby Care – Routine examinations of an infant under the age of twenty-four (24) months for whom no diagnosis is made.

ARTICLE III. SCHEDULE OF ELIGIBILITY

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

NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE BENEFIT PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.

A. Eligibility

1. Subscriber. To be eligible to enroll as a Subscriber, an individual must be an Eligible Student of the University who meets eligibility rules. For a complete definition of Eligible Student, Group and Subscriber, see Article II – Definitions.

2. Dependent. Dependents of an Eligible Student may not enroll unless the Eligible Student is also covered under the Benefit Plan. To be eligible to enroll as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated as outlined in this Benefit Plan:

   a. Spouse: The Subscriber's legal Spouse. If both Spouses are Eligible Students of the University, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

   b. CHILDREN: If both parents of a Dependent child are enrolled as Subscribers, only one parent may enroll the child as a Dependent. The Subscriber's child who is: under twenty-six (26) years of age and is one of the following:

      (1) born of the Subscriber; or

      (2) legally placed for adoption with the Subscriber; or

      (3) legally adopted by the Subscriber; or

      (4) a child for whom the Subscriber or his Spouse has been granted legal custody or provisional custody by mandate, or a child for whom the Subscriber or his Spouse is a court appointed tutor/tutrix; or

      (5) a Dependent child supported by the Subscriber pursuant to a Qualified Medical Child Support Order; or

      (6) a stepchild of the Subscriber; or

      (7) any grandchild residing with the Subscriber, provided the Subscriber has been granted legal custody or provisional custody by mandate of the grandchild; or

      (8) the Subscriber's child or grandchild who is in the legal custody of and residing with the Subscriber, who is covered on the Plan before turning twenty-six (26), and is able to remain covered on the Plan once turning age twenty-six (26) because he meets the definition and requirements of an Over-Age Dependent.

B. Application for Coverage

1. Every Eligible Person may enroll for coverage under this Benefit Plan and may include any Eligible Dependents.

2. The University will submit all enrollment information to Us as a prerequisite to coverage under this Benefit Plan.

3. No person will be covered under this Benefit Plan unless We have accepted the enrollment form or enrollment information in a format acceptable to Us and have issued an ID card or other written notice of acceptance. Payment of premiums to Us for any person will not effectuate coverage unless and until Our ID card or other written acceptance has been issued, and in the absence of such issuance, Our liability will be limited to refund of the premiums paid.

C. Available Classes of Coverage

The following classes of coverage are available on this policy:

1. Subscriber Only coverage means coverage for the Subscriber only.

2. Subscriber and Spouse coverage means coverage for the Subscriber and his Spouse.

3. Subscriber and family coverage means coverage for the Subscriber, his Spouse, and one or more Dependent children.

4. Subscriber and child (or children) coverage means coverage for the Subscriber and one or more Dependent children.

D. Enrollment and Effective Date

1. Initial Enrollment Period

Eligible Students and their Dependents may enroll for coverage under this policy during the Initial Enrollment Period by completing an enrollment form. The Initial Enrollment Period is the time agreed to by the University and Us and is the first period of time when Eligible Students can enroll themselves and any Dependents.

When enrollment has been accepted and any premiums for coverage have been paid, coverage will begin on the following applicable Effective Date.

If a person is an Eligible Student on the University's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, enrollment is accepted, and premiums are paid, the University’s Benefit Plan Date will be the Effective Date of coverage.

2. Open Enrollment Period

The University may provide an Open Enrollment Period of a minimum of thirty (30) days, during which Eligible Students may enroll themselves and any Dependents for coverage. The Open Enrollment Period shall be provided on a semi-annual and summer-only basis.

If a person becomes an Eligible Student after the University's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) during an Open Enrollment Period, and the enrollment form is received by Us within thirty (30) days of the Eligibility Date and premiums are paid, the Effective Date of coverage will be the Eligibility Date.

Eligible Students that missed the Initial enrollment Period may enroll themselves and Dependents at the next Open Enrollment Period. Any enrollment not received by Us within thirty (30) days of the Eligibility Date or within 60 days of a Special Enrollment Period as described below will be denied.

If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and family coverage or Subscriber and child(ren) coverage), and the enrollment form is received by the Company within sixty (60) days of the date of birth, the Effective Date of coverage will be the date of birth.

3. Annual and Semi-Annual 'Effective Date'

The University designates an "Annual Effective Date," "Fall Semi-Annual Effective Date," "Spring Semi-Annual Effective Date" or "Summer Effective Date" for Members newly enrolled under the Plan. If you enroll for coverage during the Initial Enrollment Period, your coverage begins on either the "Annual Effective Date" or the "Fall Semi-Annual Effective Date" specified by the University. If you enroll for coverage during an Open Enrollment Period, your coverage begins on either the "Spring Semi-Annual Effective Date" or the "Summer Effective Date" specified by the University. Effective dates are shown on the Schedule of Benefits.

E. **Court Ordered Determination**

If a court ordered determination is made to cover an eligible Dependent under this Student's Benefit Plan, the Eligible Student must enroll himself, if not already enrolled, and enroll the eligible Dependent by completing an enrollment form and submitting the enrollment form to Our home office within sixty (60) days after the court ordered determination. If timely enrolled, coverage for the eligible Dependent will be effective on the date of the court ordered determination.

F. Special Enrollment

1. Special Enrollment Due to Loss of Certain 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 an intentional misrepresentation of a material fact in connection with the plan) are not Special Enrollees and have no special enrollment rights.

An Eligible Person who is not enrolled under this Contract may be permitted to enroll as a Special Enrollee if each of the following conditions is met:

a. The Eligible Person must be eligible for coverage under the terms of this Contract;

b. The Eligible Person must have declined enrollment under this Contract when offered;

c. The Eligible Person lost coverage under a plan considered to be Creditable Coverage for HIPAA Portability purposes;

d. The Eligible Person coverage described in c. above:

(1) was under a COBRA continuation provision and the COBRA continuation period was exhausted due to one of the following:

(a) the full COBRA continuation period was exhausted;

(b) the employer or other responsible entity failed to remit required premiums on a timely basis;

(c) the individual whose coverage is through a Health Maintenance Organization (HMO), no longer lives, resides or works in the Service Area the HMO services, whether or not the choice of the individual in the Service Area, and there is no other COBRA coverage available;

(d) the individual incurs a Claim that would meet or exceed a lifetime limit on all Benefits and there is no other COBRA continuation coverage available to the individual; or

(2) was not under a COBRA continuation provision and lost other health coverage due to:

(a) loss of eligibility for coverage. Loss of eligibility for coverage includes but is not limited to the following:

(i) loss of eligibility as a result of legal separation, divorce, loss of Dependent status, death,

termination of employment, or reduction in the hours of employment;

(ii) in the case of coverage offered through a Health Maintenance Organization (HMO) in the individual market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual;

(iii) in the case of coverage offered through an HMO in the group market, loss of coverage because the individual no longer lives, resides or works in a service area the HMO services, whether or not the choice of the individual, and no other health coverage is available to the individual; or

(iv) a plan no longer offers any Benefits to the class of similarly situated individuals.

(b) termination of employer or group contributions to the other coverage.

A Special Enrollee under this section must request enrollment for coverage under this Benefit Plan within sixty (60) days after other coverage ends (or after the University stops contributing toward the other Non-COBRA coverage). If such enrollment is received by a Blue Cross and Blue Shield of Louisiana office within sixty (60) days after loss of other coverage, coverage will become effective on the date other coverage is lost. Coverage will not be available if Blue Cross and Blue Shield of Louisiana does not receive the request for enrollment form within sixty (60) days of the loss of other coverage. Enrollment must be requested during the next Open Enrollment Period.

2. Special Enrollment Due to Loss of Coverage under the Children's Health Insurance Program or a Medicaid Program

   a. This Benefit Plan provides a Special Enrollment Period for an Eligible Student or family Dependent(s) if either (1) covered under Medicaid or State Children's Health Insurance Program ("CHIP"), and loses that coverage because of loss of eligibility; or (2) becomes eligible for premium assistance under the CHIP program. To qualify, the Eligible Student must request coverage in this Benefit Plan no later than sixty (60) days after either the date of coverage termination under Medicaid or CHIP or the date Eligible Student or Dependent is determined to be eligible for such premium assistance. Request for special enrollment under this section must be received by a Blue Cross and Blue Shield of Louisiana office within the sixty (60) day period following loss of coverage or the date the Subscriber or Dependent is determined to be eligible for premium assistance. When special enrollment under this section is made timely and received by the Company timely, coverage will become effective on the date of the loss of coverage under Medicaid or CHIP, or the date the Subscriber or Dependent is eligible for premium assistance.

   b. An Eligible Student may disenroll a child Dependent from this coverage and enroll the child in CHIP coverage effective on the first day of any month for which the child is eligible for such CHIP coverage. Student must promptly notify Us in writing of the child's disenrollment to avoid continued coverage under this Plan.

3. Special Enrollment Due to Acquiring a Dependent

   a. This Benefit Plan shall provide for a Special Enrollment Period during which the Dependent of a current Subscriber may be enrolled on the plan.

   b. A person becomes a Dependent of a Subscriber, through marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, the Spouse of the Subscriber may be enrolled as a Dependent if he is otherwise eligible for coverage.

   c. If the University offers multiple health plan options, another option may be chosen by the Subscriber for himself and Dependents when special enrollee status applies.

   d. There is a thirty (30) day period of automatic coverage for Newly Born Infants (natural born or adopted), as described below.

e. The Special Enrollment Period described in this subparagraph is a period of no less than sixty (60) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied.

f. In the case of a birth, adoption, or placement for adoption, a current Subscriber may enroll himself, his Spouse and/or the newborn/adopted child. The enrollment must be requested by signing an enrollment form no later than sixty (60) days after the birth, adoption, or placement for adoption. If the enrollment form is received by a Blue Cross and Blue Shield of Louisiana office no later than sixty (60) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption or placement for adoption for an adopted Newly Born Infant. A Subscriber may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth.

g. In the case of marriage, a current Subscriber may enroll himself and the new Dependents acquired because of the marriage. The enrollment must be requested by signing an enrollment form within sixty (60) days of the marriage. Coverage will become effective on the date of marriage if the enrollment is received by a Blue Cross and Blue Shield of Louisiana office within thirty (30) days of the marriage. If the enrollment form is not received by Us within thirty (30) days of marriage, but is received within sixty (60) days of marriage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if the enrollment form is not signed within thirty (30) days of the marriage. Coverage will not be available if We do not receive the enrollment form within sixty (60) days of marriage. Enrollment must be requested during the next enrollment period.

4. Automatic Coverage Period for Newly Born Infants (Newborns)

a. Such child will be covered automatically for thirty (30) days from birth or until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit to his home, whichever is longer. This is the automatic coverage period. Automatic coverage for the child will be provided on the mother's policy, if any. If the mother has no policy, then automatic coverage will be provided on the father's policy, provided he has notified Us of the birth of the child. Coverage for the child will continue in effect thereafter, only upon Our receipt of a completed Change of Status Card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the child are paid when billed.

b. If the completed Change of Status Card is not received within this period, coverage for the child will terminate thirty (30) days from birth or when the newborn is discharged from the Hospital, whichever is longer. Any later request to add coverage for the child must be made at Open Enrollment Period or under a special enrollment provision.

c. The automatic coverage period is shorter than the Special Enrollment Period.

5. Automatic Coverage Period for Newly Born Adopted Infants

If within thirty (30) days of the birth of a child, the child is either: legally placed into the Subscriber’s home for adoption following a voluntary act of surrender to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber, the following will apply:

a. The child will be covered automatically for thirty (30) days from the date of legal placement into the Subscriber’s home or from the custody order, or if an ill newborn, from the date the child could have been legally placed into the Subscriber’s home had he not been ill, until the child is well enough to be discharged from the Hospital or neonatal Special Care Unit, whichever is longer. The infant will not be covered from birth. Coverage for the infant will continue in effect thereafter, only upon Our receipt of a completed Change of Status card prior to the expiration of the period of automatic coverage, provided any premiums required for coverage of the infant are paid when billed.

b. If the completed Change of Status Card is not received within this period, coverage for the child will terminate thirty (30) days from birth or when the newborn is discharged from the Hospital, whichever is longer. Any later request to add coverage for the child must be made at Open Enrollment Period or under a special enrollment provision.

c. The automatic coverage period is shorter than the Special Enrollment Period.

6. In all special enrollee circumstances, an Eligible Student must be enrolled in this Benefit Plan in order for his Dependent(s) to be enrolled.

ARTICLE IV. BENEFITS

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

A. Benefit Categories

1. Network Benefits (In-Network) – Benefits for medical care received from a Preferred Care Provider. When a Member receives care from a Network Provider, the Member will receive the highest level of Benefits on this plan.

2. Non-Network Benefits (Out-of-Network) – Benefits for medical care received from a Provider who is not contracted with Us as a Preferred Care Provider. Participating Providers and Non-Participating Providers are not contracted with Our Preferred Care PPO Network. When a Member receives care from a Non-Network Provider, the Member will receive a lower level of Benefits on this plan.

B. Coinsurance

If a Coinsurance is shown on the Schedule of Benefits for a Covered Service, the Member must first pay any applicable Deductible Amount before the Coinsurance. After any applicable Deductible Amount has been met, and subject to the maximum limitations and other terms and provisions of this Benefit Plan, We will provide Benefits in the Coinsurance shown on the Schedule of Benefits toward Allowable Charges for Covered Services. Our actual payment to a Provider or payment to the Member satisfies Our obligation to provide Benefits under this Benefit Plan.

C. Copayment Services

The Member may pay one or more Copayments each time applicable Covered Services are rendered. The amount of the Copayment depends on the service and the type of Network Provider rendering the service. Office visit Copayments, if applicable, will be shown on the Schedule of Benefits.

If applicable, the office visit Copayment may be reduced when services are rendered by a Quality Blue Provider. Quality Blue Providers include any Provider who has signed a contract to participate in the Quality Blue program.

1. Examples of Covered Services subject to Copayments:

   a. Office visit charges and consultation;

   b. Surgical procedures performed in the Physician’s office;

   c. Injections, allergy serums, and vials of allergy medications;

   d. Dialysis;

e. Chemotherapy;

f. Infusion therapy; and or

g. Diabetes education

2. The following services are covered at 100% of the Allowable Charge when obtained in the office and performed by a Network Physician or other Provider who is subject to an office visit Copayment:

   a. Radiation treatment;

   b. Low-Tech Imaging; and

   c. Lab tests.

3. Copayments do not apply to every service and/or supply rendered in an office setting. Examples of services rendered in an office setting that are subject to a Deductible Amount and applicable Coinsurance are listed below:

   a. Allergy testing;

   b. Prescription Drugs administered in a Provider's office:

   c. Medical and surgical supplies;

   d. High-Tech Imaging Services, including but not limited to MRIs, MRAs, CT Scans, PET Scans and nuclear cardiology.

D. Out-of-Pocket Amount

1. After the Member has met the applicable Out-of-Pocket Amount shown on the Schedule of Benefits, We will pay one hundred percent (100%) of the Allowable Charges for Covered Services for the remainder of the Plan Year.

2. The following accrue to the Out-of-Pocket Amount of this Benefit Plan:

   a. Deductible Amounts;

   b. Coinsurances; and

   c. Copayments.

3. The following do not accrue to the Out-of-Pocket Amount of this Benefit Plan:

   a. any charges in excess of the Allowable Charge;

   b. any penalties the Member or Provider must pay;

   c. charges for non-covered services; and

   d. any amounts paid by the Member other than Deductible Amounts, Coinsurance, and Copayments.

4. Amounts paid by Members for Covered Services provided by Participating and Non-Participating (collectively Non-Network) Providers will accrue to the Out-of-Pocket Amount for Network Providers when required by law.

E. Accumulator Transfers

Members' needs sometimes require that they transfer from one policy to another. Types of transfers include, but are not limited to moving from one Employer's plan to another, from a change in assignment to a different plan variation of the same Qualified Health Plan during a Benefit Period, from a Group policy to an individual policy, an individual policy to a Group policy, or a Blue Cross and Blue Shield of Louisiana policy to an HMO Louisiana, Inc. policy. The type of transfer being made determines whether the Member's accumulators are carried from the old policy to the new policy. Accumulators include, but are not limited to, Deductible Amounts and Out-of-Pocket Amounts.

ARTICLE V. NEEDLE STICK BENEFIT

Coverage is provided for Eligible Students for testing and prophylactic treatment of blood borne diseases following at risk contact with blood or other body fluids from human or animal sources. The contact may include, but is not limited to, needle sticks. This Benefit will cover 100% of the Blue Cross and Blue Shield of Louisiana Allowable Charge for the physical evaluation, Physician office visit, student health clinic, Outpatient facility, Hepatitis and HIV Antibody and Antigen tests, and an initial round of Hepatitis B vaccine. This Benefit Plan does not cover any inpatient admission, additional or follow-up testing or treatment not specific to needle sticks, antiviral or antibiotic treatments or pharmacy Benefits outside of those specifically listed under the Prescription Drug Benefit section of the Schedule of Benefits.

Covered drugs are Prophylaxis Drugs, Truvada and Isentress. These drugs are covered as follows:

- To be prescribed when a student has come in contact with a potentially contaminated needle during the course of their training.
- Covered at 100%; There is no member cost share.
- Benefit is limited to a 3-day supply per occurrence.

Hepatitis/ HIV Antibody/Antigen Test and Vaccines are covered at a 100%.

Lab services are covered at 100%.

The only claims that are eligible for the 100% coverage are claims submitted with ICD 10 codes W46.1XXA, W46.1XXD, W46.1XXS, Z57.8 and Z77.21 regardless of the place of treatment.

ARTICLE VI. HOSPITAL BENEFITS

All Admissions (including, but not limited to, elective or non-Emergency, Emergency, Pregnancy Care Admissions) must be Authorized as shown on the Schedule of Benefits, in the Care Management and Pregnancy Care and Newborn Care Benefits Articles. In addition, at regular intervals during the Inpatient stay, the Company will perform a Concurrent Review to determine the appropriateness of continued hospitalization as well as the level of care. The Member must pay any Copayment, Deductible Amount, and any Coinsurance shown on the Schedule of Benefits.

If a Member receives services from a Physician in a Hospital-based clinic, the Member may be subject to charges from the Physician and/or clinic as well as the facility.

The following services furnished to a Member by a Hospital are covered:

A. Inpatient Bed, Board and General Nursing Service

1. Hospital room and board and general nursing services.
2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.
3. In a Skilled Nursing Facility or Unit or while receiving skilled nursing services in a Hospital or other facility approved by Us.
4. In a Residential Treatment Center for Members with Mental Health and substance use disorder Benefits.

B. Other Hospital Services (Inpatient and Outpatient)

1. Use of operating, delivery, recovery and treatment rooms and equipment.
2. Drugs and medicines including take-home Prescription Drugs.
3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.
4. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee.
5. Medical and surgical supplies, casts, and splints.
6. Diagnostic Services rendered by a Hospital employee.
7. Physical Therapy provided by a Hospital employee.
8. Psychological testing when ordered by the attending Physician and performed by an employee of the Hospital.

C. Emergency Room (Facility Only)

The Member must pay an Emergency Room Copayment, if shown on the Schedule of Benefits, for each visit the Member makes to a Hospital or Allied Health Facility for Emergency Medical Services.

The Emergency Room Copayment is waived if the visit results in an Inpatient Admission.

D. Pre-Admission Testing

Benefits will be provided for the Outpatient facility charge and associated professional fees for Diagnostic Services rendered within seventy-two (72) hours of a scheduled procedure performed at an Inpatient or Outpatient Facility.

ARTICLE VII. MEDICAL AND SURGICAL BENEFITS

Benefits for the following medical and surgical services are available and may require Authorization. See the Schedule of Benefits to determine which services require Authorization. A Member must pay any applicable Copayments, Deductible Amounts, and Coinsurance shown on the Schedule of Benefits.

A. Surgical Services

1. Surgery

   a. The Allowable Charge for Inpatient and Outpatient Surgery includes all pre-operative and post-operative medical visits. The pre-operative and post-operative period is defined and determined by Us and is that period of time which is appropriate as routine care for the particular surgical procedure.

   b. When performed in the Physician's office, the Allowable Charge for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

2. Multiple Medical or Surgical Services - When Medically Necessary multiple services (concurrent, successive, or other multiple medical or surgical services) are performed at the same encounter, Benefits will be paid as follows:

   a. Primary Service

      (1) The primary or major service will be the determined by Us.

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

   b. Secondary Services

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

   c. Incidental Service

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

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

   d. Unbundled Services

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

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

   e. Mutually Exclusive Services

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

of the codes. One or more of the duplicative services is not reimbursable as it should be reimbursed only one time.

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

3. Assistant Surgeon

An assistant surgeon is a Physician, licensed physician assistant, certified registered nurse first assistant (CRNFA), registered nurse first assistant (RNFA), or certified nurse practitioner. Coverage for an assistant surgeon is provided only if the use of an assistant surgeon is required with reference to nationally established guidelines. The Allowable Charge for the assistant surgeon is based on a percentage of the fee paid to the primary surgeon.

4. Anesthesia

a. General anesthesia services are covered when requested by the operating Physician and performed by a certified nurse anesthetist (CRNA) or Physician, other than the operating Physician or the assistant surgeon, for covered surgical services. Coverage is also provided for other forms of anesthesia services as defined and approved by Us. Medical Direction or supervision of anesthesia administration includes pre-operative, operative and post-operative anesthesia administration care.

b. Anesthetic or sedation procedures performed by the operating Physician, his assistant surgeon, or an advanced practice registered nurse will be covered as a part of the surgical or diagnostic procedure unless We determine otherwise.

b. Benefits for anesthesia will be determined by applying the Coinsurance to the Allowable Charge based on the primary surgical procedure performed. Benefits are available for the anesthesiologist or CRNA who performs the service. When an anesthesiologist medically directs or supervises the CRNA, payment may be divided between the supervision and administration of anesthesia when billed separately.

5. Second Surgical Opinion

Benefits are available for Consultation and directly related Diagnostic Services to confirm the need for elective Surgery. The Physician that provides a second or third opinion must not be the Physician who first recommended elective Surgery. A second or third opinion is not mandatory to receive Benefits.

B. Inpatient Medical Services

Subject to provisions in the sections pertaining to Surgery and Pregnancy Care in this Benefit Plan, Inpatient Medical Services include:

1. Inpatient medical care visits

2. Concurrent Care

3. Consultation (as defined in this Benefit Plan)

C. Outpatient Medical and Surgical Services

1. Home, office, and other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. Benefits for Outpatient medical services do not include separate payments for routine pre-operative and post-operative medical visits for Surgery or Pregnancy Care.

2. Services of an Ambulatory Surgical Center

3. Consultation (as defined in this Benefit Plan)

ARTICLE VIII. PRESCRIPTION DRUG BENEFITS

Prescription Drugs are covered as shown below. Refer to your Schedule of Benefits to see which Prescription Drug Benefit applies to You.

A. The Prescription Drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist or a pharmacy technician under the direction of a licensed pharmacist, upon the prescription of a Physician or an Allied Health Professional who is licensed to prescribe drugs. Benefits are based on the Allowable Charge that We determine and only those Prescription Drugs that We determine are Medically Necessary will be covered. Certain Prescription Drugs may be subject to Step Therapy or require prior Authorization as shown on the Schedule of Benefits.

B. Some pharmacies have contracted with Us or with Our Pharmacy Benefit Manager to accept a negotiated amount as payment in full for the covered Prescription Drugs that they dispense. These pharmacies are "Participating Pharmacies." Benefits are based on the Allowable Charge as determined by Us. The Allowable Charge for covered Prescription Drugs purchased from Participating Pharmacies is based on the amount We pay Our Pharmacy Benefit Manager. We use the amount We pay Our Pharmacy Benefit Manager to base Our payment for the Member's covered Prescription Drugs and the amount that the Member must pay for covered Prescription Drugs. To obtain contact information for "Participating Pharmacies", the Member should contact Our customer service department or Our Pharmacy Benefit Manager at the telephone number on the ID card.

C. The Member should present the ID card to the pharmacist when purchasing covered Prescription Drugs at a Participating Pharmacy. The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. If the Member has not met his Prescription Drug Deductible Amount, the Participating Pharmacy may collect one hundred percent (100%) of the discounted costs of the drug at the point of sale. If the member has met his Prescription Drug Deductible Amount, he will pay the Copayment or Coinsurance shown on the Schedule of Benefits. The Participating Pharmacy will electronically submit the Claim for the Member.

D. Prescription Drug Formulary

This Benefit Plan covers Prescription Drugs and uses a closed Prescription Drug Formulary. A Prescription Drug Formulary is a list of Prescription Drugs covered under this Benefit Plan. Within the Prescription Drug Formulary, drugs are placed on different tiers which represent varying cost share amounts. In general, Prescription Drugs on lower tiers will cost You less than drugs on higher tiers. For covered drugs that are listed on the formulary, Our Drug Utilization Management Program, more fully described in the section below, may apply.

Information about your formulary is available to you in several ways. Most Members receive information from Us by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy**, or request a copy by mail by calling Our Pharmacy Benefit Manager at the telephone number indicated on the ID card.

You may also contact Us at the telephone number on the ID card to ask whether a specific drug is included in Your formulary. If a Prescription Drug is on your Prescription Drug Formulary, this does not guarantee that Your prescribing healthcare Provider will prescribe the drug for a particular medical condition or mental illness.

A closed formulary means that selected Brand-Name Drugs, Generic Drugs, and Specialty Drugs when listed on the formulary are covered. Drugs that are not listed on the closed formulary, also called non-formulary drugs, are not covered.

For Prescription Drugs that are not included in Our Prescription Drug Formulary, there is a drug formulary exception process. This process allows You, Your designee or Your prescribing healthcare Provider to ask for a formulary exception from Us. This request must be based on Medical Necessity. If the request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary. If the request is not approved, You may file an internal or external formulary exception request to Us.

Prescription Drug Benefits

1. The Prescription Drug Deductible Amount, if shown on the Schedule of Benefits, must be satisfied before any Copayment or Coinsurance will apply. The Member may be required to pay a different Copayment or Coinsurance for the different drug tiers. The Member may be required to pay a different Copayment or Coinsurance depending on whether the Member's Prescription Drugs are purchased at retail or through the mail. Prescription Drugs may be subject to quantity limitations.

2. The Prescription Drug Copayment or Coinsurance is based on the following tier classifications shown on the Schedule of Benefits. Tier placement is based on Our evaluation of a particular medication's clinical efficacy, safety, cost, and pharmacoeconomic factors. You may call customer service or go to **www.bcbsla.com/pharmacy** to identify the tier classification of Your Prescription Drug.

3. If a formulary exception request is approved, You will receive coverage for the drug that is not on the Prescription Drug Formulary at Tier 3 if it is a non-Specialty Drug and at Tier 4 if it is a Specialty Drug.

   a. Tier 1 - Value Drugs: Primarily Generic Drugs, although some Brand-Name Drugs may fall into this category.

   b. Tier 2 – Brand-Name Drugs

   c. Tier 3 - Primarily Brand-Name Drugs that may have a therapeutic alternative that is in Tier 1 or Tier 2, although some Generic Drugs may fall into this category.

      Covered compounded drugs are included in this Tier.

   d. Tier 4 - Specialty Drugs: High-cost Brand-Name Drugs or Generic Drugs that are identified as Specialty Drugs.

E. Drug Utilization Management Program

Our Drug Utilization Management Program features a set of closely aligned programs that are designed to promote Member safety, appropriate and cost-effective use of medications, and monitor healthcare quality. Examples of these programs include:

1. Prior Authorization – As part of Our Drug Utilization Management program, Members and/or Physicians must request and receive prior Authorization for certain Prescription Drugs and supplies in order to access Prescription Drug Benefits. The Schedule of Benefits contains a list of categories of Prescription Drugs that require prior Authorization. However, this list may change from time to time. The list of categories of Prescription Drugs that require prior Authorization is available for viewing on our website at **www.bcbsla.com** or by calling the customer service telephone number on the ID card. If the Prescription Drug requires prior Authorization, the Member's Physician must call the medical Authorization telephone number on the ID card to obtain the Authorization. Failure to obtain an Authorization may result in Benefits being denied if the Prescription Drug is later determined not to be Medically Necessary.

2. Safety checks – Before the Member's prescription is filled, Our Pharmacy Benefit Manager or We perform quality and safety checks for usage precautions, drug duplication, and frequency of refills (e.g., refill prior to seventy-five (75%) day supply used).

3. Quantity Per Dispensing Limits/Allowances – Prescription Drugs selected by Us are subject to quantity limits per day supply, per dispensing event, or any combination thereof. Quantity Per Dispensing Limits/Allowances are based on the following: (a) the manufacturer's recommended dosage and duration of therapy; (b) common usage for episodic or intermittent treatment; (c) FDA-approved recommendations and/or clinical studies; or (d) as determined by Us.

4. Step Therapy – Certain drugs and/or drug classes are subject to Step Therapy. In some cases, We may require the Member to first try one or more Prescription Drug to treat a medical condition before We will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, We may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then We will cover a prescription written for Drug B. However, if Your Physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the drug.

5. Step Therapy Overrides – Your Provider prescribing the Prescription Drug may request a Step Therapy override.

    a. Step Therapy overrides are provided for stage-four advanced, metastatic cancer or associated conditions when certain criteria exist; step therapy overrides are also provided for other conditions when certain criteria are met.

    b. When a Step Therapy Override request is submitted, We will respond to the request within seventy-two hours unless exigent circumstances exist, in which case We will respond to the request within twenty-four hours. If We do not make the determination timely, then the override request is considered approved.

    c. If a Step Therapy Override request is denied, an Appeal can be submitted.

F. Select diabetic supplies, including, but not limited to, necessary continuous glucose monitors and associated supplies, insulin syringes, and test strips are covered under the Prescription Drug Benefit.

G. When a Member purchases covered Prescription Drugs from a pharmacy that has not contracted with Us or with Our Pharmacy Benefit Manager or when a Member files a paper Claim with Us or with Our Pharmacy Benefit Manager, the Allowable Charge is the amount that the Company pays Our Pharmacy Benefit Manager for covered Prescription Drugs.

H. Prescription Drugs purchased outside of the United States must be the equivalent to drugs that by Federal law of the United States require a prescription. For covered Prescription Drugs and supplies purchased outside of the United States, the Member should submit Claims on Our Prescription Drug Claim form. For information on how to file Claims for foreign Prescription Drug purchases, the Member should contact Us or Our Pharmacy Benefit Manager at the telephone number indicated on the ID card.

I. As part of Our administration of Prescription Drug Benefits, We may disclose information about the Member's Prescription Drug utilization, including the names of prescribing Physicians, to any treating Physicians or dispensing pharmacies.

J. Any savings or rebates We receive on the cost of drugs purchased under this Benefit Plan from drug manufacturers are used to stabilize rates. You may be subject to an excess consumer cost burden when Covered Prescription Drugs are purchased under this Contract. (La. R.S. 22:976.)

ARTICLE IX. PREVENTIVE OR WELLNESS CARE

The following Preventive or Wellness Care services are available to a Member. If a Member receives Covered Services for Preventive or Wellness from a Network Provider, Benefits will be paid at 100% of the Allowable Charge, unless otherwise stated below. If a Member receives Covered Services for Preventive or Wellness Care from a Non-Network Provider, Benefits will be subject to Copayments (if applicable) and Coinsurance shown on the Schedule of Benefits. The Deductible Amount will apply to Covered Services received from a Non-Network Provider, unless otherwise stated below. Preventive or Wellness Care services may be subject to other limitations shown on the Schedule of Benefits.

A. Well Woman Examinations

1. Routine visits to Network Providers for obstetrical or gynecological care. Additional visits to a Provider for obstetrical or gynecological care may be subject to the Deductible Amount, Copayment or Coinsurance shown on the Schedule of Benefits, if not a preventive service.

2. One (1) routine Pap smear per Plan Year.

3. All film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost when obtained from a Network Provider. Mammograms obtained from a Non-Network Provider will be subject to Coinsurance as shown on the Schedule of Benefits.

4. When required by applicable law, Breast MRIs will be covered under this Preventive or Wellness Care Benefit, but not at one hundred percent (100%). The Deductible Amount will not apply for Breast MRIs. Benefits will be subject to Coinsurance shown on the Schedule of Benefits for High-Tech Imaging Services. Any MRIs that are not covered under this Preventive or Wellness Care Benefit may be covered under standard Benefits for High-Tech Imaging Services when Medically Necessary.

B. Physical Examinations and Testing

1. Routine Wellness Physical Exam – Certain routine wellness diagnostic tests ordered by Your Physician are covered. Examples of routine wellness diagnostic tests that would pay under this Preventive or Wellness Care Benefit include, but are not limited to tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.

   High-Tech Imaging Services such as an MRI, MRA, CT Scan, PET Scan, and nuclear cardiology are not covered under this Preventive or Wellness Care Benefit. These High-Tech Imaging Services are covered under standard contract Benefits when the tests are Medically Necessary.

2. Well Baby Care – Routine examinations will be covered for infants under the age of 24 months for whom no diagnosis is made. Routine examinations ordered after the infant reaches 24 months will be subject to the Routine Wellness Physical Exam Benefit.

3. Prostate Cancer Screening – One (1) digital rectal exam and prostate-specific antigen (PSA) test per Plan Year, is covered for Members fifty (50) years of age or older, and as recommended by his Physician if the Member is over forty (40) years of age. The Plan Year Deductible Amount does not apply.

   A second visit shall be permitted if recommended by the Member's Physician for follow-up treatment within sixty (60) days after either visit if related to a condition diagnosed or treated during the visits.

4. Colorectal Cancer Screening – a Fecal Immunochemical Test (FIT) for blood, Cologuard (FIT-fecal) DNA testing, Computed Tomographic (CT) colonography, flexible sigmoidoscopy, or routine colonoscopy provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in Consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

Selected generic Physician prescribed colonoscopy preparation and supplies for routine colonoscopies under the Preventive or Wellness Benefit will be covered at no cost to the Member when obtained from a Network Pharmacy. Routine colorectal cancer screening shall not mean services otherwise excluded from Benefits because the services are deemed by Us to be Investigational. Brand-name colonoscopy preparation and supplies will be covered at no cost to the Member only under the following circumstances: Physician prescribes brand-name colonoscopy preparation and supplies because of Member's inability to tolerate selected generic colonoscopy preparation and supplies.

5. Bone Mass Measurement – scientifically proven tests for the diagnosis and treatment of osteoporosis if a Member is:

   a. an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;

   b. an individual receiving long-term steroid therapy; or

   c. an individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.

6. BRCA1 and BRCA2 Genetic Testing – Genetic testing of BRCA1 and BRCA2 genes will be covered at no cost to You when obtained from a Network Provider to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force recommendations.

C. Preventive or Wellness Care Required by the Patient Protection and Affordable Care Act

Services recommended by the United States Preventive Services Task Force (receiving grades of A or B), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration are covered. You may view a copy of Our Preventive Care Services brochure by visiting Our website at: **www.bcbsla.com/preventive**.

The list of covered services changes from time to time. To check the current list of recommended Preventive or Wellness Care services required by PPACA, visit the United States Department of Health and Human Services' website at: **https://www.healthcare.gov/preventive-care-benefits/.** or contact Our customer service department at the telephone number on ID card.

Members may obtain information on the exceptions process related to the coverage of contraceptive services on Our website **bcbsla.com/birthcontrol**. This exception process is only applicable to plans which cover contraceptive services.

D. New Recommended Preventive or Wellness Care Services

New services are covered by this Benefit Plan on the date required by law for such coverage.

ARTICLE X. PREGNANCY AND NEWBORN CARE BENEFITS

Benefits are available for Pregnancy Care furnished by a Hospital, Physician, or Allied Health Provider to a Member whose coverage is in effect at the time such services are furnished in connection with her pregnancy.

An Authorization is required for a Hospital stay in connection with childbirth for the covered mother or covered well newborn **only if** the mother's length of stay exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. An Authorization is required if a newborn's stay exceeds that of the mother. An Authorization is also required for a newborn that is admitted separately because of neonatal Complications.

We have several maternity programs available to help pregnant Members deliver healthy babies. Please call Our customer service department at the number on the ID card when You learn You are having a baby. When You call, We will let You know what programs are available to You.

A. Pregnancy Care Benefits

1. Medical and Surgical Services

    a. Initial office visit and visits during the term of the pregnancy.

    b. Diagnostic Services.

    c. Delivery, including necessary prenatal and postnatal care.

    d. Medically Necessary abortions required in order to save the life of the mother.

2. Doula Services

    Maternity support services are available when provided by a registered Doula to pregnant and birthing women and their families before, during, and after childbirth. Benefits are limited to $1500 per pregnancy when services are rendered by a Network Doula and are subject to any applicable Copayment, Deductible Amount and Coinsurance. Services rendered by a Non-Network Doula are not covered.

3. Hospital services required in connection with pregnancy and Medically Necessary abortions as described above are covered. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care. As determined by Us, well newborn charges may be covered if the Member under this Contract is the father.

4. Elective deliveries prior to the thirty-ninth (39th) week of gestation will be denied as not Medically Necessary unless medical records support Medical Necessity. Facility and other charges associated with an elective early delivery that is not Medically Necessary will also be denied.

B. Newborn Care for a Dependent Who is Covered at Birth

1. Medical and Surgical services rendered by a Physician, for treatment of illness, prematurity, postmaturity, congenital condition and for circumcision of a newborn are covered. Services of a Physician for Inpatient Well Baby Care immediately following delivery until discharge are covered.

2. Hospital Services, including services related to circumcision during the newborn's post-delivery stay and treatment of illness, prematurity, postmaturity, or congenital condition of a newborn. Charges for services for a well newborn, including the Hospital (nursery) charge, should not be billed separately from the mother's Hospital bill. As determined by Us, well newborn charges may be covered if the Member under this Contract is the father.

a. The Hospital (nursery) charge for a well newborn is included in the mother's Benefits for the covered portion of her Admission for Pregnancy Care.

b. An Inpatient Hospital Admission Copayment applies to the Admission of an ill newborn for treatment in a Network Hospital. We will provide Benefits of one hundred percent (100%) of the Allowable Charges for such treatment, less the Member's Copayment. Benefits for Hospital Covered Services for treatment of an ill newborn at a Non-Network Hospital will be determined by applying the Coinsurance shown on the Schedule of Benefits to Allowable Charges for those services.

C. Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a Physician or other health care Provider obtain Authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain prior Authorization. For information on prior Authorization, contact Our customer service department at the number on the ID card.

ARTICLE XI. REHABILITATIVE AND HABILITATIVE CARE BENEFITS

Rehabilitative and Habilitative Care Benefits will be available for services and devices provided on an Inpatient or Outpatient basis, including services for Occupational Therapy, Physical Therapy, Speech/Language Pathology Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, and Chiropractic Services. Benefits are available when the therapy is rendered by a Provider licensed and practicing within the scope of his license. In order for care to be considered at an Inpatient Rehabilitation facility, the Member must be able to tolerate a minimum of three (3) hours of active therapy per day.

An Inpatient Rehabilitation Admission must be Authorized prior to the Admission and must begin within seventy-two (72) hours following the discharge from an Inpatient Hospital Admission for the same or similar condition, unless otherwise approved by Us.

Day Rehabilitation Programs for Rehabilitative Care may be Authorized in place of Inpatient stays for rehabilitation. Day Rehabilitation Programs must be Authorized prior to beginning the program and must begin within seventy-two (72) hours following discharge from an Inpatient Admission for the same or similar condition, unless otherwise approved by Us.

A. Occupational Therapy

1. Occupational Therapy services are covered when performed by a Provider licensed and practicing within the scope of his license, including, but not limited to a licensed occupational therapist, a licensed and certified Occupational Therapy assistant supervised by a licensed occupational therapist, or a licensed advanced practice registered nurse.

2. Occupational Therapy must be referred or ordered by a Physician, advanced practice registered nurse, dentist, podiatrist, or optometrist prior to the receipt of services.

3. Prevention, wellness and education related services for Occupational Therapy shall not require a referral.

B. Physical Therapy

1. Physical Therapy services are covered when performed by a licensed physical therapist practicing within the scope of his license.

2. A licensed physical therapist may perform an initial evaluation or Consultation of a screening nature to determine the need for Physical Therapy.

3. Physical Therapy must be prescribed or referred by a Physician, dentist, podiatrist, or chiropractor prior to the receipt of services. However, Physical Therapy may be provided without the prescription or referral of a Physician, dentist, podiatrist or chiropractor when performed under the following circumstances, if listed as a Covered Service:

   a. To children with a diagnosed developmental disability pursuant to the Member's plan of care.

   b. As part of a Home Health Care agency pursuant to the Member's plan of care.

   c. To a patient in a nursing home pursuant to the Member's plan of care.

   d. Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress, or promotion of fitness.

   e. To an individual for a previously diagnosed condition or conditions for which Physical Therapy services are appropriate after informing the healthcare Provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety (90) days. The physical therapist shall provide the healthcare Provider who rendered such diagnosis with a plan of care for Physical Therapy services within the first fifteen (15) days of Physical Therapy intervention.

C. Speech/Language Pathology Therapy

1. Speech/Language Pathology Therapy services are covered when performed by a Provider licensed to practice in the state in which the services are rendered and practicing within the scope of his license, including, but not limited to, a speech pathologist or by an audiologist.

2. The therapy must be used to improve or restore speech/language, speech/language development disorders, cognitive communication, or swallowing function.

3. Speech/Language Pathology Therapy must be prescribed by a Physician prior to the receipt of services.

D. Chiropractic Services

1. Chiropractic Services are covered when performed by a chiropractor licensed and practicing within the scope of his license.

2. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

ARTICLE XII. PEDIATRIC DENTAL CARE BENEFITS

The dental Benefits described in this section are available for Members under the age of nineteen (19) only.

Members who attain age nineteen (19) during a Plan Year will continue to have these Benefits until the end of that Plan Year. Members that age off the coverage under this section may be eligible to purchase other dental coverage through Blue Cross and Blue Shield of Louisiana. Please contact a customer service representative for details. The Schedule of Benefits controls the Benefits covered, the frequency with which they are covered, and the cost sharing applicable to each Benefit. The Benefits offered are limited.

In accordance with federal law, We will provide benefits for all required pediatric dental services. Services will be subject to any duration and frequency limits and exclusions as identified in the federal benchmark plan.

A. Definitions *(Applicable only to this Pediatric Dental Care Benefits Article of this plan)*

1. Allowable Charge – The lesser of the billed charge or the amount established by UCD as the greatest amount this plan will allow for a specific service covered under the terms of this plan.

2. Amalgam – A durable metal alloy comprised of silver, copper, tin and mercury, used in dental restorations.

3. Authorization (Authorized) – A determination by UCD regarding a dental healthcare service or supply which, based on the information provided, satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the healthcare setting, or level of care and effectiveness. An Authorization is not a guarantee of payment. Additionally, an Authorization is not a determination about the Member's choice of Provider.

4. Benefits - Coverage for dental services, treatments or procedures provided under this plan. Benefits are based on the Allowable Charge for Covered Services and the Schedule of Benefits.

5. Claim - A Claim is written or electronic proof, in a form acceptable to UCD, of charges for Covered Services that have been incurred by a Member during the time-period the Member was insured under this plan. The provisions in effect at the time the service or treatment is received shall govern the processing of any Claim expense actually incurred as a result of the service or treatment rendered.

6. Coinsurance - The sharing of Allowable Charges for Covered Services. The sharing is expressed as a percentage. Once the Member has met any applicable Deductible Amount, the Company's percentage will be applied to the Allowable Charge for Covered Services to determine the Benefits provided.

7. Cosmetic Surgery/Treatment - Any procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form. A procedure, treatment or service will not be considered Cosmetic Surgery or Treatment if that procedure, treatment or service restores bodily function or corrects deformity of a part of the body that has been altered as a result of Accidental Injury, disease or covered surgery.

8. Covered Service - A service or supply specified in this plan for which Benefits are available when rendered by a Provider.

9. Crown - A tooth-shaped cap that is placed over a tooth to cover it and restore its shape and size, strength, and improve its appearance. When a crown is cemented into place, it fully encases the entire visible portion of a tooth that lies at and above the gum line.

10. Deductible - The dollar amount, if shown on the Schedule of Benefits, of Allowable Charges for Covered Services that each Member must pay within a Plan Year before payments are made under this plan. If shown on the Schedule of Benefits, the Deductible Amount may be waived for certain services.

11. Dental Care and Treatment – All procedures, treatment, and surgery considered to be within the scope of the practice of dentistry, which is defined as that practice in which a person:

a. represents himself/herself as being able to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, alveolar process, gums, or jaws or associated parts and offers or undertakes by certain means to diagnose, treat, correct, operate, or prescribe for any disease, pain, injury, deficiency, deformity, or physical condition of the same;

b. takes impressions of the human teeth or jaws or performs any phase of any operation incident to the replacement of a tooth or part of a tooth or associated tissues by means of a Filling, Crown, denture, or other appliance; or

c. furnishes, supplies, constructs, reproduces, or repairs or offers to furnish, supply, construct, reproduce, or repair Prosthetic Dentures, bridges, or other substitute for natural teeth to the user or prospective user.

12. Dental Implants – An artificial device that replaces the tooth root and may anchor an artificial tooth, bridge or denture.

13. Dental Necessity or Dentally Necessary - A dental service or procedure that is determined by UCD to either establish or maintain a patient's dental health based on professional diagnostic judgment and the prevailing standards of care in the professional community. The determination will be made by a Dentist in accordance with guidelines established by UCD.

14. Dentist - A person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioner under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

15. Endodontic (Pulpal) Therapy - A dental procedure that is performed when the decay in a child's tooth reaches into the pulp (nerve) tissue. The infected part of the nerve tissue within the crown portion of the tooth is removed to prevent further inflammation and spread of disease (caries). During this treatment, the diseased pulp tissue is partially or completely removed from both the crown and the roots of the tooth. The canals are cleansed, disinfected, and filled with a special material.

16. Filling - A dental restorative material used to restore the function, integrity and form of missing tooth structure, which may result from caries or external trauma.

17. Fluoride Treatment - Fluoride is a chemical substance that helps prevent tooth decay by making the tooth more resistant to acid attacks from plaque bacteria and sugars in the mouth. It also reverses early decay. Fluoride treatment refers to the direct application of a substance containing this substance to the tooth enamel.

18. Gingivectomy – Surgical removal of gum tissue.

19. Gingivoplasty – A surgical procedure to reshape or repair the gums.

20. Inlay - A custom-made solid substance that is fitted into a cavity in a tooth between the cusps, which is cemented into place to restore its biting surface.

21. Occlusal Guard - A horseshoe shaped piece of plastic which is worn over the teeth to protect them against damage caused by clenching or grinding. It works by creating a physical barrier between the patient's upper and lower teeth so that he/she bites against the plastic rather than wearing down his/her teeth.

22. Onlay - A custom-made solid substance that works like an Inlay but covers one or more cusps or the entire biting surface of the tooth. It is usually used when the tooth is too damaged to support an Inlay, but not damaged enough to require a Crown.

23. Orthodontics - A dental specialty that treats misalignment of teeth.

24. Periodontal Scaling and Root Planing - The process of removing or eliminating etiologic agents (dental plaque, its products, and calculus) which cause inflammation, and help to maintain disease-free tissues that surround and support the teeth.

25. Prefabricated Stainless Steel Crown - A Crown made of stainless steel that is premanufactured in a variety of sizes and are intended to be fitted upon a child's primary tooth which is damaged, to simulate its original form, decrease the risk of future cavities, save the proper amount of space for the eruption of the permanent tooth, and restore the child's ability to bite and chew.

26. Prosthetic Dentures - Prosthetic devices constructed to replace missing teeth, and which are supported by surrounding soft and hard tissues of the oral cavity. Conventional dentures are removable, however there are many different denture designs, some which rely on bonding or clasping onto teeth or Dental Implants.

27. Provider – A Physician or Dentist, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by UCD. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

    a. Participating Provider – A Provider that has a Provider Agreement with the United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

    b. Non-Participating Provider – A Provider that does not have a Provider Agreement with the United Concordia Dental Advantage Plus Network to render Covered Services to a Member.

28. Provider Agreement – An agreement for payment contracted by UCD with Participating Providers. These agreements establish the actual payments which will be made to the Participating Provider.

29. Resin-Based Composite – Material composed of plastic with small glass or ceramic particles, which resemble the appearance of natural teeth.

30. Sealant - Plastic material usually applied to the chewing surfaces of the back teeth (premolars and molars) where decay occurs most often, so that they act as a barrier to prevent cavities.

31. Space Maintainer – Besides being useful for chewing, baby teeth also act as a guide for the eruption of the permanent teeth that replaces them. If a baby's tooth is lost too early, the permanent tooth that comes after it loses its guide, so it could drift or erupt into the wrong position in the mouth. Neighboring teeth also can move or tilt into the space, reducing the space available for the permanent tooth to come out. Space Maintainers are appliances used when a baby tooth is lost too early to help make room for the permanent tooth it was intended to guide.

32. Temporomandibular Joint (TMJ) Disorders – Disorders resulting in pain and/or dysfunction of the Temporomandibular Joint which arise out of rheumatic disease, dental occlusive disorders, internal or external joint stress, or other causes.

33. UCD – United Concordia Companies, Inc. d/b/a United Concordia Dental, the Network and claims administrator for the pediatric dental Benefits in this plan and oral Surgery provided by an Advantage Plus Participating Provider.

B. Diagnostic and Preventive Services

After the Member's payment of the corresponding Deductible Amount and Coinsurance, according to the Schedule of Benefits, this plan will cover:

1. Oral Exams

    a. One (1) periodic, limited problem-focused or comprehensive oral exam every six (6) months.

b. One (1) detailed problem-focused oral evaluation every six (6) months.

2. Oral Cleanings (Prophylaxis)

   a. Limited to one (1) every six (6) months

   b. One (1) additional cleaning during the Plan Year will be allowed for Members that are under the care of a medical professional during pregnancy

3. Fluoride Treatment

   a. Limited to children under nineteen (19) years old; and

   b. Limited to two (2) topical application every twelve (12) months

4. Sealants

   a. Limited to children under nineteen (19) years old, and only for permanent first and secondary molars; and

   b. Limited to one (1) per tooth every thirty-six (36) months

5. Consultations

   a. Diagnostic services provided by a Dentist or Physician other than practitioner providing the dental treatment.

6. Emergency (Palliative) Treatment

7. Oral Radiographs (X-Rays)

   a. Complete series intraoral X-rays or panoramic film X-rays, limited to one (1) film every sixty (60) months; and

   b. Bitewing X-rays limited to one (1) set every six (6) months

C. Basic Services

1. Space maintainers

   a. Covered when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars or deciduous molars and permanent first molars that have not or will not develop; and

   b. Includes coverage for recementation of Space Maintainer.

2. Amalgam Restorations (Metal Fillings)

3. Resin-Based Composite Restorations (White Fillings)

4. Crown Repairs – Recementation, restoration and pin retention

   Recementation that becomes necessary during the first twelve (12) months following insertion by the same Provider is considered to be a part of the original Benefit

5. Prefabricated Stainless Steel Crowns

   a. Limited to Members under fifteen (15) years old; and

b. Limited to one (1) per tooth every thirty-six (36) months.

D. Major Services

1. Endodontic (Pulpal) Therapy

   a. Only covered if performed after forty-five (45) days from a root canal, otherwise will be considered part of the root canal.

   b. Limited to primary incisor teeth for Members up to age six (6) and for primary molars and cuspids up to age eleven (11).

   c. Limited to one (1) per eligible tooth per lifetime.

2. Root Canal

3. Surgical Periodontics

   a. Gingivectomy or gingivoplasty, limited to one (1) every thirty-six (36) months.

   b. Gingival flap procedure limited to one (1) every thirty-six (36) months.

   c. Clinical crown lengthening

   d. Osseous surgery limited to one (1) every thirty-six (36) months.

   e. Guided tissue regeneration limited to one (1) per tooth per lifetime.

   f. Pedicle soft tissue graft limited to one (1) every thirty-six (36) months.

   g. Free soft tissue graft

   h. Subepithelial connective tissue graft

   i. Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to one (1) per lifetime.

4. Non-Surgical Periodontics

   a. Periodontal scaling and root planing limited to one (1) every twenty-four (24) months for each area of the mouth

5. Periodontal Maintenance

   a. Limited to four (4) every twelve (12) months in addition to routine Prophylaxis

6. Simple Extractions

   a. Extraction of erupted tooth or exposed root

7. Surgical Extractions

   a. Surgical removal of erupted tooth with elevation of mucoperiosteal flap and removal of bone and/or section of tooth

8. Oral Surgery

   a. Removal of impacted tooth

b. Surgical removal of residual tooth roots

c. Coronectomy-intentional partial tooth removal

d. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

e. Surgical access to an unerupted tooth

f. Alveoloplasty

g. Removal of exostosis

h. Intraoral soft tissue incision and drainage of abscess.

i. Suture of recent small wounds.

j. Excision of pericoronal gingival

9. Anesthesia

   a. Anesthesia for dental services covered only when Dentally Necessary

   b. Includes deep sedation/general anesthesia; or Intra-venous conscious sedation/analgesia

   c. If the Member has a medical condition that requires dental services which would ordinarily be provided in a dental office to be performed in a Hospital setting, the anesthesia services will be covered exclusively under the medical coverage of this plan and not under this pediatric dental Benefit.

10. Prosthetic Dentures

    a. Includes complete, fixed, removable or partial dentures.

    b. Limited to one (1) every sixty (60) months.

11. Inlays, Onlays and Crowns

    a. Crowns, inlays, onlays, core buildup including pins, and prefabricated post and core; and

    b. All limited to one (1) per tooth every sixty (60) months

12. Adjustments, Repairs and replacement of Prosthetic Dentures

13. Other Prosthetic Services

    a. Rebase or reline of mandibular or maxillary complete or partial dentures, limited to one every 36 months. Covered only for six (6) months after the initial installation.

    b. Tissue conditioning

    c. Recementation or repair of fixed partial denture

       (1) Recementation during the first twelve (12) months following insertion from the same Dentist is included in the prosthetic service Benefit.

14. Dental Implants

    a. Implants must be Dentally Necessary and are covered only when the arch cannot be restored with a standard prosthesis or restoration.

    b. The following implant Benefits are limited to one (1) every sixty (60) months

        (1) endosteal, eposteal, and transosteal implants;

        (2) connecting bar;

        (3) prefabricated abutment;

        (4) abutment supported crowns;

        (5) implant supported crowns;

        (6) abutment supported retainers for dentures;

        (7) implant supported retainers for dentures;

        (8) implant maintenance procedures;

        (9) repair of implant prosthesis;

        (10) replacement of semi-precision or precision attachment;

        (11) repair of implant abutment;

        (12) implant removal;

        (13) implant index; and

        (14) surgical placement of interim implant body

    c. Implant supported complete or partial dentures.

15. Occlusal Guard

    a. Limited to one (1) every twelve (12) months; and

    b. Limited to patients that are thirteen (13) years of age and older.

16. Adjunctive General Services

    a. Therapeutic drug injection

    b. Treatment of Complications from oral surgery in unusual circumstances (for example but not limited to, treatment of dry socket following extraction or removal of bony sequestrum).

E. Medically Necessary Orthodontics

Covered Benefits include services for limited, interceptive and comprehensive Orthodontic treatment of the primary, transitional and adolescent dentition in addition to removable and fixed appliance therapy. Treatment visits are provided for pre-Orthodontic, periodic Orthodontic and Orthodontic retention.

Orthodontic services will only be covered if the Member fits the following criteria:

1. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive Orthodontic services.

2. **All Orthodontic services require Authorization,** a written plan of care, and must be rendered by a Provider.

3. Orthodontic treatment must be considered medically necessary and be the only method considered capable of:

   a. Preventing irreversible damage to the Member's teeth or their supporting structures.

   b. Restoring the Member's oral structure to health and function.

4. A Medically Necessary Orthodontic service is an Orthodontic procedure that occurs as a part of an approved orthodontic treatment plan that is intended to treat a severe dentofacial abnormality or serious handicapping malocclusion. **Orthodontic services for cosmetic purposes are not covered.**

5. Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the Member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.

6. Dentofacial abnormalities that severely compromise the Member's physical health may be manifested by:

   a. Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together.

   b. Under-developed lower jaw and receding chin.

   c. Marked asymmetry of the lower face.

7. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

   a. Obvious difficulty in eating because of the malocclusion, so as to require a liquid or semisoft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.

   b. Obvious severe breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic mouth breathing and postural abnormalities relating to breathing difficulties.

   c. Lisping or other speech articulation errors that are directly related to orofacial abnormalities and cannot be corrected by means other than Orthodontic intervention.

F. Pre-Determination

Pre-determination of dental Benefits is a service available through UCD. This Benefit review in advance of treatment enables you and your Dentist to see what services are covered by the plan and what your cost sharing and other costs would be.

Pre-determination should not be requested unless total charges for a proposed treatment plan exceed $200. You may ask your Dentist to submit a pre-determination request. UCD will then provide a summary of covered expenses and payable amounts.

Please note that Pre-Determinations are not designed to be used for Emergency treatments or routine preventive services such as exams, x-rays or cleanings.

A pre-determination is not an Authorization. When a Covered Benefit needs to be Authorized, a formal Authorization request prior to service will have to be submitted.

G. Alternate Benefits

If UCD determines that a less costly covered service other than the covered service the Dentist performed could have been performed to treat a dental condition, we will pay Benefits based upon the less costly service if such service would produce a professionally acceptable result under generally accepted dental standards. If the Member and the Dentist choose the more expensive treatment, the Member will be responsible for the additional charges, beyond those allowed under this clause. This limitation does not apply to covered implantology services.

Alternate Benefits applicable to your treatment plan will be determined during Authorization. However, should the services billed differ from those Authorized, UCD reserves the right to determine if an alternate Benefit is applicable to the actual services rendered.

H. Coordination of this Section with Stand-Alone Dental Contracts

If a Member has stand-alone coverage for dental Benefits that includes coverage for the Benefits provided for under this plan, the dental Benefits under the stand-alone coverage will be determined first. Then, the Benefits under this section will be determined on a secondary basis and will be reduced, so that no more than the full amount of the Allowable Charge is paid under all the dental Benefits for the same Claim or service.

I. Benefit Extension Period After Termination of Coverage

1. The dental coverage under this section will be extended after the date the coverage for the Member terminates only if:

    a. A covered Benefit for such service was incurred while coverage was in effect; and

    b. Such covered Benefit is completed within thirty-one (31) days after coverage terminates.

2. A covered Benefit expense will be deemed incurred as follows:

    a. For appliances or changes to appliances – on the date the appliance or prosthesis is permanently placed;

    b. For Crowns, dentures or bridgework – on the date the impression is taken;

    c. For root canal therapy -- on the date the pulp chamber is opened; or

    d. For all other dental expenses -- on the date the service is rendered or the supply is furnished.

J. Exclusions

Only American Dental Association procedure codes are covered under this section. Except as specifically provided in this plan and Schedule of Benefits, no coverage will be provided under this section for services, supplies or charges that are:

1. Started prior to the Member's Effective Date or after the termination date of coverage under this plan, including, but not limited to, multi-visit procedures such as endodontics, Crowns, bridges, Inlays, Onlays, and dentures.

2. For house or Hospital calls for dental services and for hospitalization costs (e.g., facility-use fees).

3. The responsibility of any federal or state workers' compensation laws and/or related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes, whether or not coverage under such laws or programs is actually in force, the responsibility of employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. Benefits would be in excess to the third-party Benefits and therefore, We would have right of recovery for any Benefits paid in excess. Our right of subrogation is contingent on the right of the covered insured to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or a judgment following a trial.

4. Cosmetic in nature as determined by UCD (for example but not limited to, bleaching, veneer facings, personalization or characterization of Crowns, bridges and/or dentures).

5. Maxillofacial prosthetics.

6. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).

7. For congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including Orthodontic treatment). Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies and Equipment Article of this Contract.

8. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under this plan. Examples of these jaw joint problems are temporomandibular joint disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint.

9. For treatment of fractures and dislocations of the jaw.

10. For treatment of malignancies or neoplasms.

11. For services and/or appliances that alter the vertical dimension (for example but not limited to, full-mouth rehabilitation, splinting, Fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

12. For replacement or repair of lost, stolen or damaged prosthetic or Orthodontic appliances.

13. For periodontal splinting of teeth by any method.

14. For duplicate dentures, prosthetic devices or any other duplicative device.

15. For which in the absence of insurance the Member would incur no charge.

16. For plaque control programs, oral hygiene and dietary instructions.

17. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

18. For treatment and appliances for bruxism (night grinding of teeth) with exception of an Occlusal Guard.

19. For any Claims submitted to the Company or UCD later than fifteen (15) months after the date of service.

20. For incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limited to, temporary restorations).

21. For procedures that are:

    a. part of a service but are reported as separate services; or

    b. reported in a treatment sequence that is not appropriate; or

    c. misreported or that represent a procedure other than the one reported.

22. For specialized procedures and techniques (for example but not limited to precision attachments, copings and intentional root canal treatment).

23. Fees for broken appointments.

24. Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of UCD will apply.

25. Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and a written treatment plan is approved by Us. Orthodontic services for the following are excluded:

    a. Treatments that are primarily for Cosmetic reasons

    b. Treatments for congenital mouth malformations or skeletal imbalances (e.g., treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including Orthodontic treatment). Coverage for Cleft Lip and Cleft Palate Services is provided in the Other Covered Services, Supplies and Equipment Article of this Contract.

    c. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Schedule of Benefits. Examples of these jaw joint problems are temporomandibular joint disorders (TMJ) or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint.

26. Posterior resin fillings.

27. Administration of nitrous oxide.

ARTICLE XIII. PEDIATRIC VISION CARE BENEFITS

The vision Benefits described in this section are available for Members under the age of nineteen (19) only.

Members who attain age nineteen (19) during a Plan Year will continue to have these Benefits until the end of that Plan Year. The Schedule of Benefits controls the Benefits covered, the frequency with which they are covered, and the cost sharing applicable to each Benefit. The Benefits offered are limited.

A. Definitions *(Applicable only to this Pediatric Vision Care Benefits Article of this plan)*

1. Bifocal Lenses – A lens containing two different powers: one for distance vision and one for near vision. Bifocal Lenses can be lined or unlined. Lined Bifocal Lenses are those in which both powers are easily distinguished by a line between them. Unlined Bifocal Lenses are those in which both powers are not easily distinguishable.

2. Blended-Segment Lenses – A lens containing two different powers, one for distance, and one for near. Segment with near prescription is invisible.

3. Company – Blue Cross and Blue Shield of Louisiana (incorporated as Louisiana Health Service & Indemnity Company), or Davis Vision, Inc. in regards to the services it renders on Blue Cross and Blue Shield of Louisiana's behalf.

4. Contact Lenses – Devices that correct refractive errors in vision and are comprised of a small shell-like lens that is worn externally resting directly on the eye. To include soft lens, daily wear, disposable/planned replacement, extended wear, gas permeable, hard, medically necessary, monovision, scleral shell, and toric.

5. Digital Surface Technology Progressive Lenses – A lens that is designed to provide correction for more than one viewing range, in which the power changes continuously rather than discretely. The digital surfacing technology refers to a digital manufacturing technique that uses proprietary software to define a unique progressive lens fully customized to the wearer's prescription, fitting geometry and frame information before cutting this design into the lens.

6. Evaluation and Fitting – Means the professional individualized fitting of Contact Lenses and the professional evaluation to check that the prescription is correct and that there is no irritation of the eyes.

7. Eyeglass Frame – Plastic or metal structure for holding Spectacle Lenses.

8. Fashion Tinting – Tints that are used primarily for cosmetic purposes.

9. Glass-Grey #3 Prescription Sunglass Lenses – Glass lenses that turn grey when exposed to the sun's ultraviolet light.

10. Gradient Tinting – A Spectacle Lens coating that is darker at the top of the lens, fading to lighter at the bottom.

11. High-Index Lenses – Material that results in thinner (almost one-third) Spectacle Lenses than normal plastic. Does not contain the impact resistant qualities of polycarbonate.

12. Intermediate-Vision Lens – A Trifocal Lens or blank which has been designed to correct vision at ranges intermediate to distant and near objects.

13. Lenticular Lenses – A lens, usually of strong refractive power, in which the prescribed power is applied over only a limited central region of the lens, called the lenticular portion.

14. Medically Necessary Contact Lenses – Contact Lenses that are determined as Medically Necessary in the treatment of the following conditions: Keratoconus, Anisometropia, Corneal Disorders, Pathological Myopia, Aniseikonia, Post-Traumatic Disorders, Aphakia, Aniridia and Irregular Astigmatism. In general,

Medically Necessary Contact Lenses may be prescribed in lieu of eyeglasses, when it will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

15. Monocular Patient – Refers to a patient who sees out of only one eye.

16. Oversize Lenses – A larger than standard lens type that requires special frames and equipment to fabricate the eyeglasses.

17. Pediatric Contact Lenses Selection or Selection Contact Lenses – A selection of Contact Lenses offered to Members by Davis Vision through Participating Providers.

18. Pediatric Eyeglass Frames Selection or Selection Frames – A selection of Eyeglass Frames offered to Members by Davis Vision thorough Participating Providers.

19. Photochromic Glass Lenses – Glass Spectacle Lenses that darken when exposed to the ultraviolet rays of the sun.

20. Plastic Photosensitive Lenses – Plastic lenses that darken when exposed to the sun's ultraviolet rays.

21. Polarized Lenses – Spectacle Lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

22. Polycarbonate Lens – A Spectacle Lens made of a high impact-resistant material used for safety in children's eyewear, sports and other cosmetic purposes. Lenses are 20-25% thinner than "regular plastic.

23. Premium Anti-Reflective Coating – A non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection with superior smudge resistance and optimum clean-ability, such as Crizal™ or equivalent. Advanced forms of Anti-Reflective Coatings for Spectacle Lenses with improved durability.

24. Premium Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with a newer, branded progressive lens design or a proprietary, digitally manufactured design. Lenses are often referred to as "free-form design" or "wave-front technology" to help minimize peripheral distortion.

25. Provider – An ophthalmologist, optometrist, optician, Physician, or legally authorized eyeglass and Contact Lens retail store, licensed where required, performing within the scope of license, and approved by the Company. If a Provider is not subject to state or federal licensure, We have the right to define all criteria under which a Provider's services may be offered to Our Members in order for Benefits to apply to a Provider's Claims. Claims submitted by Providers who fail to meet these criteria will be denied.

    a. Participating Provider – A Provider that has a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member.

    b. Non-Participating Provider – A Provider that does not have a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member.

26. Routine Eye Health Examination – A level of service in which a general evaluation of the complete visual system of the human body is made. This includes:

    - Case history (chief complaint, eye and vision history, medical history)
    - Entrance distance and near acuities, with and without current lenses
    - External ocular evaluation
    - Internal ocular examination
    - Tonometry
    - Refraction (objective and subjective)
    - Binocular coordination and ocular motility evaluation

- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan
- Advising the patient on matters pertaining to vision care
- Form completion (e.g., school, motor vehicle); and
- A Dilated Fundus Examination (DFE) when professionally indicated (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systematic diseases)

27. Scratch Protection Plan – An optional plan that will replace scratched lenses with new lenses of the same material, style and prescription, at no charge for a period of one (1) year from the original date of dispensing. A Scratch Protection Plan may be available for single vision lenses only, for multifocal vision lenses only, or for both.

28. Scratch-Resistant Coating – Coating applied to Spectacle Lenses to increase the scratch resistance of the lens surface.

29. Select Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with a newer, proprietary progressive lens design.

30. Specialty Type Contact Lenses – Contact Lenses that are newer in the market than Standard Type Contact Lenses and require a specialty fitting. These lens types include, but not limited to toric, multifocal and gas permeable lenses.

31. Spectacle Lenses – Devices that correct refractive errors in vision which are intended to be mounted on Eyeglass Frames to be worn externally, involving a transparent medium bounded by two geometrically describable surfaces one of which shall be curved, that is, spherical, cylindrical, toroidal or aspheric.

32. Standard Anti-Reflective Coating – A non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection, such as Aegis™ Anti-Reflective Treatment or equivalent.

33. Standard Progressive Lenses – Lenses with variable power zones from far distance to near distance correction with an older, proven branded progressive lens design.

34. Standard Type Contact Lenses – Commonly used Contact Lens types defined as spherical clear Contact Lenses. These include disposable Contact Lenses planned replacement lenses and others.

35. Trifocal Lenses – A multifocal lens with three different powers in three different positions. Usually, the top (largest) portion is for distance vision, the middle portion is for intermediate distances and the bottom portion is for near vision. Trifocal Lenses can be lined or unlined. Lined Trifocal Lenses are those in which the different powers are easily distinguished by a line between them. Unlined Trifocal Lenses are those in which the different powers are not easily distinguishable.

36. Ultra Anti-Reflective Coating – Non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection. The ultra-coating uses the latest lens material technologies with all the Benefits of both standard and premium lenses.

37. Ultra Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with the newest branded progressive lens design technology, including a digitally manufactured design.

38. Ultraviolet Coating – A coating for Spectacle Lenses that blocks ultraviolet rays.

B. Vision Benefits

The Schedule of Benefits control how the Benefits described in this Article are covered under the Member's Benefit Plan, with what frequency, and what limitations apply to them. **Any vision Benefit listed in this Benefit Plan that is not mandated by state or federal law may be deleted or revised on the Schedule of Benefits.** Please refer to the Schedule of Benefits for details.

1. In-Network Benefits

   Subject to the specifications described on the Schedule of Benefits, each Member will have coverage for the following services, if received from Participating Providers:

   a. One (1) Routine Eye Health Examination

      The Company will cover one (1) Routine Eye Health Examination as stated on the Schedule of Benefits. Covered Routine Eye Health Examinations will include dilation of eye pupils when professionally indicated.

   b. Prescription Spectacle Lenses For Each of the Member's Eyes

      The Company will cover one (1) prescription Spectacle Lens for each of the Member's eyes, as stated on the Schedule of Benefits. The Schedule of Benefits explain if the Member has additional coverage for some special types of lens material and enhancements, and the Copayment that applies to each. Lens materials or enhancements not specifically mentioned on the Schedule of Benefits are not covered.

   c. Pediatric Eyeglass Frame Selection

      The Company will cover one (1) Selection Frame as stated on the Schedule of Benefits. Participating Providers will show the Member the selection of frames covered by this plan. If the Member does not select a Selection Frame, he will be responsible for the difference in cost between the Selection and non-Selection frame. Any amount paid to the Provider for the difference in cost of a non-Selection Frame is not covered and will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket Amount. Any Frame purchased from a Non-Participating Provider will be considered a non-Selection Frame, and will be subject to the Non-Network Benefit limitations.

   d. Prescription Pediatric Contact Lenses Selection

      The Company will cover Prescription Selection Contact Lenses, in lieu of eyeglasses, and up to the maximum of pairs or boxes for conventional or planned replacement Contact Lenses stated on the Schedule of Benefits. Participating Providers will inform the Member of the Contact Lenses selection covered by this plan. If the Member chooses non-Selection Contact Lenses, he will be responsible for the difference in cost between the Selection and non-Selection Contact Lenses. Any amount paid to the Provider for the difference in cost of a non-Selection Contact Lens is not covered and will not apply to any applicable Deductible, Coinsurance, or Out-of-Pocket Amount. Any Contact Lens purchased from a Non-Participating Provider will be considered a non-Selection Contact Lens, and coverage will be limited according to the Non-Network Benefit section.

   e. Low Vision Benefits

      Subject to prior Authorization, Members with Low Vision will receive the following:

      (1) One (1) comprehensive evaluation every five (5) years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

      (2) One (1) device per year such as high-power spectacles, magnifiers and telescopes. These devices

are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs.

(3) Four (4) follow-up visits in any five-year period.

C. Limitations to In-Network Benefits

1. Medically Necessary Contact Lenses

   Medically Necessary Contact Lenses are subject to Authorization. Medically Necessary Contact Lenses that are not duly Authorized will not be covered.

2. Selection and Non-Selection Eyeglass Frames

   Members may choose either one (1) Selection or one (1) non-Selection Eyeglass Frame within their frequency period, but not both.

3. Contact Lens Evaluation, Fitting and Follow-up Care

   Evaluation and Fitting services for Selection Contact Lenses and Medically Necessary Contact Lenses that are provided by a Participating Provider are covered. Follow-Up services are covered up to one (1) visit only. Evaluation, Fitting and Follow-up services for non-Selection Contact Lenses are not covered.

D. Non-Network Benefits

If included according to the Schedule of Benefits, this Plan will provide limited coverage for certain services and materials rendered by Non-Participating Providers, up to the maximum amount described in the Schedule. Any charges billed by Non-Participating Providers for those services in excess of the maximum amounts described on the Schedule of Benefits will not be covered and will be the responsibility of the Member.

E. Discounts

Members may have access to discounts on vision-related services and materials not covered under this plan. Any discounts are administered and provided by Davis Vision in consideration of the Member being covered under this plan. Discounts are not to be considered coverage under this plan, unless stated otherwise in the materials describing the discount. Davis Vision may change or discontinue the discounts provided to their clients in the regular course of business. Members must consult with Davis Vision or a Davis Vision Provider to find out what discounts are available to them at any specific time.

F. Sales Taxes on Covered Items

Providers may be required in some areas to collect sales taxes over the value of covered items or services. In such cases, this coverage will not cover sales taxes. The Member must pay any sales taxes, in addition to non-covered amounts and discount priced items.

G. Exclusions

1. Implants, intacts or any kind of intraocular lenses.

2. Surgical treatments for vision correction, unless otherwise specifically covered under another part of this Benefit Plan.

3. Services or materials other than those specifically listed on the Schedule of Benefits for Vision Care and described under this part of this plan.

4. Non-prescription eyewear or Contact Lenses.

5. Any sales taxes or interest.

ARTICLE XIV. OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT

The following services are available to a Member. The Member must pay all Copayments, applicable Deductible Amounts and Coinsurance. These services, supplies or equipment may also be subject to other limitations shown on the Schedule of Benefits.

A. Ambulance Service Benefits

1. Ground Ambulance Transport Services

   a. Emergency Transport

      Benefits for Ambulance Services are available for local transportation for Emergency Medical Conditions only as follows:

      (1) for Members, to the nearest Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care;

      (2) for a Newly Born Infant, to the nearest Hospital or neonatal special care unit for treatment of illnesses, injuries, congenital birth defects and Complications of premature birth which require that level of care; or

      (3) for the Temporarily Medically-Disabled Mother of an ill Newly Born Infant when accompanying the ill Newly Born Infant to the nearest Hospital or neonatal Special Care Unit, upon recommendation by the mother's attending Physician of her need for professional Ambulance Service.

   b. Non-Emergency Transport

      Benefits for Ambulance Services are available for local transportation of Members for medical conditions that do not present an Emergency to obtain Medically Necessary Inpatient or Outpatient services when the Member is bed-confined or his condition is such that the use of any other method of transportation is contraindicated. Benefits for non-Emergency transport are only available for transport to or from the nearest facility or Hospital capable of providing the Medically Necessary services.

      The Member must meet all of the following criteria for bed-confinement to qualify for non-Emergency transport:

      (1) unable to get up from bed without assistance; and

      (2) unable to ambulate; and

      (3) unable to sit in a chair or wheelchair.

   c. Transport by wheelchair van is not a covered Ambulance Service.

2. Ground Ambulance Without Transport

   Benefits are available for ambulance response and treatment at the scene, without transporting the Member to a facility for further medical care.

3. Air Ambulance Transport Services

   a. Emergency Transport

      Benefits for air Ambulance Services are available for Members with an Emergency Medical Condition. For Emergency Medical Conditions, the air Ambulance Service must be specifically requested by police

or medical authorities present at the site with the Member in order for air Ambulance Services to be covered.

Benefits for air Ambulance Services are also available for Emergency transport when the Member is in a location that cannot be reached by ground ambulance.

The air Ambulance transport is to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care.

b. Non-Emergency Transport

Benefits for non-Emergency air Ambulance Services must be Authorized by Us before services are rendered or no Benefits are available for the services. If Authorized by Us before services are rendered, Benefits for non-Emergency air Ambulance Services are available for Members, to the nearest facility or Hospital capable of providing services appropriate to the Member's condition for an illness or injury requiring Hospital care. Once Authorized, you should verify the Network participation status of the air Ambulance Service Provider in the state or area the pick-up is to occur, based on zip code. To locate a Network Provider in the state or area where you will be receiving services, please go to the Blue National Doctor & Hospital Finder at **http://provider.bcbs.com** or call 1-800-810-2583.

4. Ambulance Service Benefits will be provided as follows:

a. If a Member pays a periodic fee to an ambulance membership organization with which the Company does not have a Provider agreement, Benefits for expenses incurred by the Member for its Ambulance Services will be based on any obligation the Member must pay that is not covered by the fee. If there is in effect a Provider agreement between the Company and the ambulance organization, Benefits will be based on the Allowable Charge.

b. The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.

c. No Benefits are available if transportation is provided for a Member's comfort or convenience.

d. No Benefits are available when a Hospital transports Members between parts of its own campus or between facilities owned or affiliated with the same entity.

B. Attention Deficit/Hyperactivity Disorder

The diagnosis of and treatment for Attention Deficit/Hyperactivity Disorder when rendered or prescribed by a Physician or Allied Health Professional is covered.

C. Autism Spectrum Disorders

Autism Spectrum Disorder Benefits include, but are not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, Habilitative and Rehabilitative Care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Applied Behavior Analysis is available for coverage for the treatment of Autism Spectrum Disorders when it is determined to be Medically Necessary.

Autism Spectrum Disorder Benefits are subject to the Copayments, Deductible Amount, and Coinsurance that are applicable to the Benefits obtained. Example: A Member obtains Speech Therapy for treatment of Autism Spectrum Disorder. The Member will pay the applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

D. Breast Reconstructive Surgery Services and Breast Cancer Long-Term Survivorship Care

1. Under the Women's Health and Cancer Rights Act, if you are receiving Benefits in connection with a mastectomy and elects breast reconstruction, You will also receive Benefits for the following Covered Services:

   a. Al stages of reconstruction of the breast on which a partial or full unilateral mastectomy has been performed or reconstruction of both breasts if a bilateral mastectomy has been performed;

   b. 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;

   c. Prostheses; and

   d. Treatment of physical Complications of all stages of the mastectomy, including lymphedema.

   These Covered Services must be delivered in a manner determined in consultation with You and Your attending Physician, if applicable, and will be subject to the any Copayments, Deductible Amounts and Coinsurance.

2. 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:

   a. were previously diagnosed with breast cancer;

   b. completed treatment for breast cancer;

   c. underwent bilateral mastectomy; and

   d. were subsequently determined to be clear of cancer.

   These Covered screenings include but are not limited to magnetic resonance imaging, ultrasound, or some combination of tests, as determined in consultation with You and Your attending Physician. Annual preventive cancer screenings under this Benefit will be subject to any Copayment, Deductible Amount and Coinsurance.

E. Cleft Lip and Cleft Palate Services

Covered Services include the following:

1. Oral and facial Surgery, surgical management, and follow-up care.

2. Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.

3. Orthodontic treatment and management.

4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

5. Speech-language evaluation and therapy.

6. Audiological assessments and amplification devices.

7. Otolaryngology treatment and management.

8. Psychological assessment and counseling.

9. Genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

F. Clinical Trial Participation

1. This Benefit Plan shall provide coverage to any Qualified Individual for routine patient costs of items or services furnished in connection with his/her participation in an Approved Clinical Trial for cancer or other Life-Threatening Illness. Coverage will be subject to any applicable terms, conditions and limitations that apply under this Benefit Plan, including Copayment, Deductible Amount, or Coinsurance shown on the Schedule of Benefits.

2. A "Qualified Individual" under this section means a Member that:

   a. Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Illness;

   b. And either,

      (1) The referring healthcare professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the requirements in paragraph a, above; or

      (2) The Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate based upon the Member meeting the conditions described in paragraph a, above.

3. An "Approved Clinical Trial" for the purposes of this paragraph means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Illness that:

   a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

      (1) The National Institutes of Health.

      (2) The Centers for Disease Control and Prevention.

      (3) The Agency for Health Care Research and Quality.

      (4) The Centers for Medicare & Medicaid Services.

      (5) Cooperative group or center of any of the entities described in paragraphs (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

      (6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

   b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

   c. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

   d. The study or investigation is conducted by any of the below Departments, which study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of

Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(1) The Department of Veterans Affairs.

(2) The Department of Defense.

(3) The Department of Energy.

4. The following services are not covered:

   a. Non-healthcare services provided as part of the clinical trial;

   b. Costs for managing research data associated with the clinical trial;

   c. The investigational drugs, devices, items or services themselves; and/or

   d. Services, treatment or supplies not otherwise covered under this Benefit Plan.

5. Treatments and associated protocol-related patient care not excluded in this paragraph shall be covered if all of the following criteria are met:

   a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other Life-Threatening Illness or for the prevention or early detection of such diseases.

   b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial.

   c. The proposed protocol must have been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.

   d. The facility and personnel providing the protocol must provide the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

   e. There must be no clearly superior, non-investigational approach.

   f. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative.

   g. The patient has signed an institutional review board approved consent form.

G. Diabetes Benefits

1. Diabetes Education and Training for Self-Management

   a. Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietitian visits and for the equipment and necessary supplies for the training, if prescribed by the treating Provider.

   b. Evaluation and training programs for diabetes self-management are covered, subject to the following:

      (1) The program must be prescribed by Member's treating Provider and provided by a licensed healthcare professional that certifies that a Member has successfully completed the training program.

(2) The program shall comply with the National Standard for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

2. Diabetic Retinal Screening

Diabetic Members are eligible to receive retinal eye screenings to detect and prevent diabetic retinopathy and other eye Complications, once per Benefit Period, at no cost to the Member when services are rendered by a Network Provider. Additional screenings or screenings by a Non-Network Provider are covered subject to standard Benefits.

H. Dietitian Visits for Nutritional Counseling

Benefits are available for Outpatient visits to registered dietitians for nutritional counseling. One (1) dietitian visit for nutritional counseling is covered at no cost to Members when the dietitian is a Network Provider. All other subsequent dietitian visits for nutritional counseling are covered at standard benefits. Dietitian visits for diabetics are available under a separate Benefit for diabetes education and training for self-management.

I. Disposable Medical Equipment and Supplies

Disposable medical equipment or supplies which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by Us. The equipment and supplies are subject to the Member's medical Deductible Amount and Coinsurance.

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

Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances and Devices (Limb and Non-Limb) are covered at the Coinsurance shown on the Schedule of Benefits.

1. Durable Medical Equipment

a. Durable Medical Equipment is covered when the equipment is prescribed by a Physician prior to obtaining the equipment. The equipment must not be provided mainly for the comfort or convenience of the Member or others. In addition, the equipment must meet all of the following criteria:

(1) It must withstand repeated use,

(2) It must be primarily and customarily used to serve a medical purpose,

(3) It must be generally not useful to a person in the absence of illness or injury, and

(4) It must be appropriate for use in the patient's home.

b. Benefits for rental or purchase of Durable Medical Equipment.

(1) Benefits for the rental of Durable Medical Equipment will be based on Our rental Allowable Charge (but not to exceed the purchase Allowable Charge).

(2) At Our option, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use.

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

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

(a) that do not serve a medical purpose;

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

(c) that are solely for the Member's comfort or convenience; or

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

(4) Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance and will not be covered separately.

(5) Repair or adjustment of purchased Durable Medical Equipment or for replacement of components is covered. Replacement due to loss, theft, misuse, abuse, neglect, or destruction is not covered. We also will not cover replacement in cases where the Member sells or gives away the equipment. Replacement of equipment within five (5) years of purchase or rental that is not Medically Necessary, as defined in this Contract will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment subject to a recall within five (5) years after purchase or rental will not be covered. Regardless of Medical Necessity, repair, adjustment, or replacement of equipment will not be covered when provided under warranty.

c. Limitations in connection with Durable Medical Equipment.

(1) There is no coverage during rental of Durable Medical Equipment for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.

(2) There is no coverage for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.

(3) There is no coverage for repair or replacement of equipment due to loss, theft, misuse, abuse, neglect, or destruction. There is no coverage for replacement of equipment in cases where the Member sells or gives away the equipment.

(4) Reasonable quantity limits on Durable Medical Equipment items and supplies will be determined by Us.

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

2. Orthotic Devices

Benefits as specified in this section will be available for the purchase of Orthotic Devices and will be subject to the following:

a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Orthotic Device.

b. Repair or replacement of the Orthotic Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the device. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of the device will not be covered when provided under warranty or when the device is subject to a recall.

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

(1) Deluxe devices or deluxe features and functionalities of devices are those:

(a) that do not serve a medical purpose;

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

(c) that are solely for the Member's comfort or convenience; or

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

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

d. No Benefits are available for supportive devices for the foot, except when used in the treatment of diabetic foot disease.

3. Prosthetic Appliances and Devices (Non-Limb)

Benefits will be available for the purchase of Prosthetic Appliances and Devices (other than limb prosthetics and services) that We Authorize, and are covered subject to the following:

a. There is no coverage for fitting or adjustments, as this is included in the Allowable Charge for the Prosthetic Appliance or Device.

b. Repair or replacement of the Prosthetic Appliance or Device is covered only after a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time-period. Regardless of Medical Necessity, repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.

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

(1) Deluxe appliances or devices or deluxe features and functionalities of appliances or devices are those:

(a) that do not serve a medical purpose;

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

(c) that are solely for the Member's comfort or convenience; or

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

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

4. Prosthetic Appliances and Devices and Prosthetic Services of the Limbs

Benefits will be available for the purchase of Prosthetic Appliances and Devices and Prosthetic Services of the limbs that We Authorize, and are covered subject to the following:

a. Repair or replacement of the Prosthetic Appliance or Device is covered only within a reasonable time-period from the date of purchase subject to the expected lifetime of the appliance. We will determine this time-period. Repair or replacement of appliances or devices will not be covered when provided under warranty or when the appliances or devices are subject to a recall.

b. When Prosthetic Appliances or Devices are approved by Us, Benefits for standard appliances or devices will be provided toward any deluxe appliance or device.

(1) Deluxe appliances or devices or deluxe features and functionalities of appliances or devices are those:

(a) that do not serve a medical purpose;

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

(c) that are solely for the Member's comfort or convenience; or

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

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

c. A Member may choose a Prosthetic Appliance or Device that is priced higher than the Benefit payable under this Benefit Plan and may pay the difference between the price of the appliance or device and the Benefit payable, without financial or contractual penalty to the Provider of the appliance or device.

d. Prosthetic Appliances and Devices of the limb must be prescribed by a licensed Physician and provided by a facility accredited by the American Board for Certification in Orthotics Prosthetics and Pedorthics (ABC) or by the Board for Orthotist/Prosthetist Certification (BOC).

K. Emergency Medical Services

1. Hospital Facility Services

a. A Member must pay an Emergency Room Copayment, if shown on the Schedule of Benefits, for each visit the Member makes to a Hospital or Allied Health Facility for Emergency Medical Services.

b. The Emergency Room Copayment, if shown on the Schedule of Benefits, is waived if the visit results in an Inpatient Hospital Admission.

2. Professional Services

A Member must pay applicable Deductible Amount and/or Coinsurance, if shown on the Schedule of Benefits, for each Provider rendering Emergency Medical Services.

L. Fertility Preservation Services

Medically Necessary standard fertility preservation services are covered for a Member receiving Medically Necessary treatment that will result in Iatrogenic Infertility.

Standard fertility preservation services include extraction, cryopreservation, and up to three (3) years of storage of oocytes and sperm. No benefits are available for Prescription Drugs whether offered as a pharmacy Benefit or medical Benefit as part of the standard fertility preservation services.

Benefits for fertility preservation services are subject to a lifetime maximum of $10,000. If storage costs have been covered for three (3) years, no additional benefits will be provided, even if the $10,000 lifetime maximum has not been met. This Benefit is subject to payment of any applicable Copayment, Deductible Amount and Coinsurance which will apply to the $10,000 lifetime maximum.

M. Gene Therapy and Cellular Immunotherapy Benefits

Gene Therapy and Cellular Immunotherapy are high cost, specialized treatments administered by a limited number of trained and quality Providers. Benefits are available for these services only: (1) WHEN WRITTEN AUTHORIZATION OF MEDICAL NECESSITY IS GIVEN BY THE COMPANY PRIOR TO SERVICES BEING

PERFORMED; AND (2) SERVICES ARE PERFORMED AT AN ADMINISTERING FACILITY THAT HAS RECEIVED PRIOR WRITTEN APPROVAL FROM THE COMPANY TO PERFORM YOUR PROCEDURE.

N. Genetic or Molecular Testing for Cancer

Genetic or molecular testing for cancer are covered under this Plan as required by law and when Medically Necessary.

O. Hearing Benefits

1. Hearing Benefits for Members age 17 and under

   Benefits are available for hearing aids for covered Members age seventeen (17) and under when obtained from a Network Provider. This Benefit is limited to one (1) hearing aid for each ear with hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist licensed hearing aid specialist or licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate to the age of the child.

   This Benefit is subject to payment of the applicable Copayment, Deductible Amount and Coinsurance.

2. Hearing Benefits for Members age 18 and older

   Benefits are available for hearing aids for covered Members age eighteen (18) and older for severe hearing loss or profound hearing loss and when obtained from a Network Provider. Severe hearing loss or profound hearing loss is defined as a pure tone average air conduction threshold of 71dB or higher measured at 0.5, 1, 2, and 3 kilohertz (kHz). This Benefit is limited to one (1) hearing aid for each ear with severe hearing loss or profound hearing loss every thirty-six (36) months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or licensed hearing aid dealer following the medical clearance of a Physician and an audiological evaluation medically appropriate for the Member.

   If more than one type of hearing aid can meet the Member's functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for the Member's needs. If the Member purchases a hearing aid that exceeds these minimum specifications, We will only pay the amount that We would have paid for the hearing aid that meets the minimum specifications, and the Member will be responsible for paying any difference in cost, without financial or contractual penalty to the Provider of the hearing aid.

   Authorization must be obtained prior to receiving a hearing aid for Members who are age eighteen (18) and older. This Benefit is subject to Medical Necessity and payment of the applicable Copayment, Deductible Amount and Coinsurance.

3. Cochlear Implants and Bone Anchored Hearing Aids (BAHA)

   Benefits are available for cochlear implants and bone-anchored hearing aids (BAHA) for all eligible Members with severe hearing loss or profound hearing loss, regardless of age, the same as any other service or supply.

   This Benefit is subject to Medical Necessity and payment of the applicable Copayment, Deductible Amount and Coinsurance.

4. Limitations in Connection with Hearing Aids or Other Hearing Devices

   Benefits for hearing aids, assistive listening devices or other devices available over-the-counter (OTC) are not covered.

Benefits for hearing aids or other hearing devices are not covered if We determine that a hearing aid, assistive listening device, or other hearing device that is available over-the-counter is a clinically appropriate or suitable treatment for a Member's hearing loss.

Replacement of hearing aids and other hearing devices that are lost or damaged due to neglect or misuse are not covered.

Repair, adjustment, or replacement of hearing aids or other hearing devices are not covered when provided under warranty or when the hearing aid or other hearing devices are subject to a recall.

Hearing aid repairs and supplies are not covered when provided by a Non-Network Provider. This limitation does not apply to Cochlear Implants or BAHA.

P. High-Tech Imaging Services

Medically Necessary High-Tech Imaging Services, including but not limited to MRIs, MRAs, CT Scans, PET Scans, and nuclear cardiology are covered. These services require prior Authorization.

Q. Home Health Care

Home Health Care services provided to a Member in lieu of an Inpatient Hospital Admission are covered.

R. Hospice Care

Hospice Care is covered.

S. Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter/transliterator are covered when the Member needs such services in connection with medical treatment or diagnostic Consultations performed by a Physician or Allied Health Professional, if the services are required because of hearing loss or his failure to understand or otherwise communicate in spoken language. These services are not covered if rendered by a family member, or if the medical treatment or diagnostic consultation is not covered.

T. Low Protein Food Products for Treatment of Inherited Metabolic Diseases

Benefits are available for low protein food products for treatment of certain Inherited Metabolic Diseases. "Inherited Metabolic Disease" shall mean a disease caused by an inherited abnormality of body chemistry. "Low Protein Food Products" shall mean those foods that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low Protein Food Products shall not include natural foods that are naturally low in protein.

Benefits for Low Protein Food Products are limited to the treatment of the following diseases:

Phenylketonuria (PKU);
Maple Syrup Urine Disease (MSUD);
Methylmalonic Acidemia (MMA);
Isovaleric Acidemia (IVA);
Propionic Acidemia;
Glutaric Acidemia;
Urea Cycle Defects;
Tyrosinemia.

U. Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed Physician or received in a Hospital or other public or private facility Authorized to provide lymphedema treatment. Coverage includes but

is not limited to multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

V. Permanent Sterilization Procedures

Benefits are available for surgical procedures that result in permanent sterilization, including vasectomy, tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes unless shown as not Covered on the Schedule of Benefits. If Covered, tubal ligation and hysteroscopic placement of micro-inserts into the fallopian tubes is available as a Preventive or Wellness Care Benefit.

W. Prescription Donor Human Breast Milk

Benefits are available for Medically Necessary pasteurized donor human breast milk prescribed for a Dependent infant, until one (1) year of age, undergoing Inpatient care or Outpatient care who is medically or physically unable to receive maternal human milk or participate in breastfeeding or whose mother is medically or physically unable to produce maternal human milk in sufficient quantities. This coverage is limited to a two-month supply per infant per lifetime and is limited to prescribed donor human breast milk obtained from a member bank of the Human Milk Banking Association of North America or other source approved by Us.

X. Prescription Drugs

Prescription Drugs approved for self-administration (e.g., oral and self-injectable drugs) must be obtained through the Prescription Drug Benefits article of this Benefit Plan.

Y. Private Duty Nursing Services

1. Coverage is available to a Member for Private Duty Nursing Services when performed on an Outpatient basis and when the RN or LPN is not related to the Member by blood, marriage or adoption.

2. Private Duty Nursing Services are covered subject to the Deductible Amount and Coinsurance shown on the Schedule of Benefits.

3. Inpatient Private Duty Nursing Services are not covered.

4. Your Contract limits coverage for Private Duty Nursing Services to three hundred (300) hours per Benefit Period.

Z. Sleep Studies

Medically Necessary home or laboratory sleep studies and associated professional Claims are eligible for coverage.

AA. Telehealth Services and Remote Patient Therapy Services

Benefits are available to You for the diagnosis, consultation, treatment, education, care management, patient self-management, and caregiver support when You and your Provider are not physically located in the same place.

Interaction between Member and Provider may take place in different ways, depending on the circumstances, but this interaction must always be suitable for the setting in which the Telehealth Services and Remote Patient Therapy Services are provided.

Telehealth Services generally must be held in real time by two-way video and audio transmissions simultaneously (Synchronous). Telehealth Services does not cover telephone calls, and only when approved by Us is it allowed by methods other than simultaneous audio and video transmission.

Store Forward or Asynchronous Telehealth Services between an established patient and their Provider may take place when an established patient sends pre-recorded video or images to a Provider via HIPAA-compliant communication at the Provider's request, or when the data is transferred between two Providers on the patient's behalf. This method of Telehealth Services is limited to services approved by Us.

Store Forward or Asynchronous Remote Patient Therapy Services between an established patient and a Provider who has an established, documented, and ongoing relationship with the patient may take place when an established patient uses an FDA-approved or FDA-authorized device to collect and electronically transmit biometric data to a Provider to be analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health condition. This method of Remote Patient Therapy Services is limited to services and devices approved by Us.

In order to be covered, Remote Patient Therapy Services must specifically be required for medical treatment decisions for the Member or as otherwise required by law and must collect and electronically transmit biometric data to an established Provider on at least sixteen (16) days of a thirty-day (30) period.

Unless prohibited by applicable law, the amount You pay for a Telehealth Services or Remote Patient Therapy Services visit may be different than the amount You would pay for the same Provider's service in a non-Telehealth or non-Remote Patient Therapy setting. You will pay more for a Telehealth visit or a Remote Patient Therapy visit when your Provider is not in your Network.

We have the right to determine if billing was appropriate and contains the required elements for Us to process the Claim.

In general, there is no coverage for Telehealth Services or Remote Patient Therapy Services that are not within the scope of the Provider's license or fail to meet any standard of care compared to an in-person visit. Coverage does not exist for non-HIPAA compliant encounters which do not provide a system of secure communication to safeguard protected health information.

Telehealth Services, Remote Patient Therapy Services, and the Providers who can render those services are determined by Us.

BB. Urgent Care Center

An Urgent Care Center Copayment, shown on the Schedule of Benefits, applies to each visit to an Urgent Care Center that is in Our Network. A Member receiving care from a Non-Network Urgent Care Center is responsible for the Coinsurance shown on the Schedule of Benefits subject to any limitations or maximum Benefits.

CC. Treatment of the Foot

Benefits for a total of six (6) services, treatments, or procedures for cutting or removal of corns and calluses are covered. Benefits for a total of six (6) services, treatments, or procedures for nail trimming and/or debridement are also covered. Benefits are limited for these services, treatments, or procedures per Benefit Period whether such services, treatments, or procedures are provided by Network Providers or Non-Network Providers. All other services, treatments, or procedures in excess of the limits are not covered. The Member must pay any applicable Copayment, Deductible Amount and Coinsurance.

ARTICLE XV. MENTAL HEALTH BENEFITS

A. Benefits for the treatment of Mental Health are available subject to any limitations shown on the Schedule of Benefits. Covered Services will be only those which are for treatment rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Benefits for the treatment of Mental Disorder do **not** include counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and employment counseling. Coverage for Mental Health includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis as approved by Us.

B. The first follow-up visit after discharge from an Inpatient facility for the treatment of a Mental Disorder is available at no cost to the Member when performed within seven (7) days of the discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to standard Benefits.

ARTICLE XVI. SUBSTANCE USE DISORDER BENEFITS

A. Benefits for treatment of substance use disorders are available. Covered Services will be only those which are treatment for abuse of alcohol, drugs or other chemicals and the resultant physiological and/or psychological dependency which develops with continued use. Treatment must be rendered by a Doctor of Medicine, Doctor of Osteopathy, or an Allied Health Professional. Coverage for substance use disorders includes services delivered through the Psychiatric Collaborative Care Model when used to treat a behavioral health diagnosis as approved by Us.

B. The first follow-up visit after discharge from an Inpatient facility for the treatment of a substance use disorder is available at no cost to the Member when performed within seven (7) days of the discharge by a Network Provider approved by Us as a behavioral health Provider. Additional visits will be paid subject to standard Benefits

ARTICLE XVII. ORAL SURGERY BENEFITS

Coverage is provided only for the following services or procedures: The highest level of Benefits are available when services are performed by Your Medical Plan Network, the Blue Cross and Blue Shield of Louisiana's dental Network, or the Advantage Plus Network. Access the Network online at **www.bcbsla.com**, or call the customer service telephone number on the ID card for a copy of the directory.

A. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.

B. Extraction of impacted teeth.

C. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.)

D. Excision of exostoses or tori of the jaws and hard palate.

E. Incision and drainage of abscess and treatment of cellulitis.

F. Incision of accessory sinuses, salivary glands, and salivary ducts.

G. Anesthesia for the above services or procedures when rendered by an oral surgeon.

H. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.

I. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders.

J. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required to restore bodily function for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth. To obtain more information on how to access these medical Benefits, please call Our customer service unit at the phone number on the ID card, and ask to speak to a Case Manager.

ARTICLE XVIII. ORGAN, TISSUE AND BONE MARROW TRANSPLANT BENEFITS

(Benefits available from In-Network Providers only)

AUTHORIZATION IS REQUIRED FOR THE EVALUATION OF A MEMBER'S SUITABILITY FOR ALL SOLID ORGAN AND BONE MARROW TRANSPLANT PROCEDURES. FOR THE PURPOSES OF COVERAGE UNDER THIS BENEFIT PLAN, ALL AUTOLOGOUS PROCEDURES ARE CONSIDERED TRANSPLANTS.

Solid organ and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered. The Member or his Provider must advise Us of the proposed transplant procedure prior to Admission and a written request for Authorization must be filed with Us. We must be provided with adequate information so that We may verify coverage, determine that Medical Necessity is documented, and approve of the Hospital at which the transplant procedure will occur. We will forward written Authorization to the Member and to the Provider(s).

A. Acquisition Expenses

If a solid organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor's medical expenses are covered as acquisition costs for the recipient under this Benefit Plan.

If any organ, tissue or bone marrow is sold rather than donated to a Member, the purchase price of such organ, tissue or bone marrow is not covered.

B. Organ, Tissue and Bone Marrow Transplants

1. Benefits for solid organ and bone marrow transplants are available only when services are rendered by a Blue Distinction Centers for Transplants (BDCT) for the specific organ or transplant or by the Blue Cross and Blue Shield of Louisiana (BCBSLA) approved facility, unless otherwise approved by Us in writing. No Benefits are available for solid organ and bone marrow transplants performed at other facilities. To locate an approved transplant facility, Members should contact Our customer service department at the number listed on the ID card.

2. Benefits for organ, tissue and bone marrow transplants are shown on the Schedule of Benefits and are not covered under the Non-Network Benefit category. Benefits are provided for Network services only.

3. Benefits for organ, tissue and bone marrow transplants include coverage for immunosuppressive drugs prescribed for transplant procedure(s).

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

   a. Solid Human Organ Transplants of the:

      (1) Liver;

      (2) Heart;

(3) Lung;

(4) Kidney;

(5) Pancreas;

(6) Small bowel; and

(7) Other solid organ transplant procedures, which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.

b. Tissue Transplant Procedures (Autologous and Allogeneic), as specified below

Tissue transplants (other than bone marrow) are covered under regular Benefits and do not require prior Authorization. However, if an Inpatient Admission is required, it is subject to the Article on Authorization of Services and Supplies.

These following tissue transplants are covered:

(1) Blood transfusions;

(2) Autologous parathyroid transplants;

(3) Corneal transplants;

(4) Bone and cartilage grafting;

(5) Skin grafting;

(6) Autologous islet cell transplants; and

(7) Other tissue transplant procedures which We determine have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case-by-case basis.

c. Bone Marrow Transplants

(1) Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.

(2) Other bone marrow transplant procedures, which We determine, have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These bone marrow transplant procedures will be considered on a case-by-case basis.

ARTICLE XIX. CARE MANAGEMENT

A. Authorization of Admissions, Services and Supplies, Selection of Provider and Penalties

For a list of items and services that require Authorization, visit Our website, **www.bcbsla.com/priorauth.**

1. Authorization and Selection of Provider

   Benefits will be paid at the highest Network level when care is received from a Network Provider. Participating and Non-Participating Providers are Non-Network Providers.

   a. If a Member wants to receive services from a Non-Network Provider and obtain Network Benefits, the Member must notify Our care management department before services are rendered. We will approve the use of a Non-Network Provider only if We determine that the services **cannot** be provided by a Network Provider within a 75-mile radius of the Member's home. The Non-Network Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Non-Network Provider.

      We must approve the use of the Non-Network Provider and issue any required Authorization before services are rendered. If We do not approve use of the Non-Network Provider and issue an Authorization prior to services being rendered, Covered Services that are later determined to be Medically Necessary will be paid at the lower Non-Network Provider level shown on the Schedule of Benefits.

   b. If We do approve the use of a Non-Network Provider, that Provider may or may not accept the Member's Copayment, Deductible Amount and Coinsurance at the time services are rendered. We will pay Benefits up to the Allowable Charge for Covered Services rendered by an approved Non-Network Provider who has obtained any required Authorization prior to services being rendered. We will deduct from Our payment the amount of the Member's Copayment, Deductible Amount and Coinsurance whether or not the Copayment, Deductible Amount and Coinsurance is accepted by the Non-Network Provider.

   An Authorization of Medical Necessity is not an approval of the use of a Non-Network Provider. These are two separate functions.

2. Penalties for Failure to Obtain Authorization – Admissions, Outpatient Services and Other Covered Services and Supplies

   If a required Authorization is not requested prior to Admission or receiving other covered services and supplies requiring an Authorization, We have the right to determine if the Admission or other covered services and supplies were Medically Necessary.

   If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Member must pay all charges incurred.

   If the Admission or other Covered Services were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services, as follows:

   a. Admissions

      (1) If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. The Network Provider or Participating Provider is responsible for all charges not covered. The Member remains responsible for any applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

(2) If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty if shown on the Schedule of Benefits. The Member is responsible for all charges not covered and for any applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

b. Outpatient Services, Including Other Covered Services and Supplies

(1) If a Network Provider fails to obtain a required Authorization, We may reduce the Allowable Charge by the penalty stipulated in the Provider's contract. This penalty applies to all Outpatient services and supplies requiring an Authorization. The Network Provider is responsible for all charges not covered. The Member remains responsible for any applicable Copayment, Deductible Amount and Coinsurance shown on the Schedule of Benefits.

(2) If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on the Schedule of Benefits. The Member is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

(3) If a service or supply was not Medically Necessary, the service or supply is not covered.

(4) If a Provider fails to obtain a required Authorization for the Outpatient services and supplies which indicate no Benefit without written / prior Authorization on the prior Authorization list, the Outpatient services and supplies are not covered.

3. Authorization of Admissions

a. Authorization of Elective Admissions

The Member is responsible for ensuring that the Provider notifies Our care management department of any Elective or non-Emergency Inpatient Hospital Admission. We must be notified prior to the Admission regarding the nature and purpose of any Elective Admission or non-Emergency Admission to a Hospital's Inpatient department. To notify Us prior to the Admission, the Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facility. The most appropriate setting for the elective service and the appropriate length of stay will be determined by the Company when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If a request for prior Authorization is denied, the Admission is not covered and the Member must pay all charges incurred during the Admission for which Authorization was denied.

(2) If Authorization is not requested prior to an Admission, We have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.

(3) Additional amounts for which the Member is responsible because Authorization of an Elective or non-Emergency Inpatient Hospital Admission was denied or not requested are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

b. Authorization of Emergency Admissions

It is the Member's responsibility to ensure that the Physician or Hospital, or a representative thereof, notifies Our care management department of all Emergency Admissions. Within forty-eight (48) hours of the Emergency Admission, We must be notified regarding the nature and purpose of the Emergency Admission. The facility or Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or

facility. We may waive or extend this time limitation if We determine that the Member is unable to timely notify or direct a representative to notify Us of the Emergency Admission. In the event, the end of the notification period falls on a holiday or weekend, We must be notified on the next working day. The appropriate length of stay for the Emergency Admission will be determined by Us when the Hospital Inpatient setting is documented to be Medically Necessary.

(1) If Authorization is denied, the Admission will not be covered and the Member must pay all charges incurred during the Admission.

(2) If Authorization is not requested, We have the right to determine if the Admission was Medically Necessary. If an Admission was Medically Necessary, Benefits will be provided based on the participating status of the Provider.

(3) Additional amounts for which the Member is responsible because Authorization of an Emergency Admission was denied or not requested are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

c. Concurrent Review

When We Authorize a Member's Inpatient stay, We will Authorize the stay in the Hospital for a certain number of days. If the Member has not been discharged on or before the last Authorized day, and the Member needs additional days to be Authorized, the Member must make sure the Physician or Hospital contacts Us to request Concurrent Review for Authorization of additional days. This request for continued hospitalization must be made on or before the Member's last Authorized day so We can review and respond to the request that day. If We Authorize the request, We will again Authorize a certain number of days, repeating this procedure until the Member is either discharged or the Member's continued stay request is denied. To request Concurrent Review for Authorization of additional days, the Provider should contact Our care management department at the telephone number shown on the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facilty.

(1) If We do not receive a request for Authorization for continued stay on or before the Member's last Authorized day, no days are approved past the last Authorized day, and no additional Benefits will be paid unless We receive and Authorize another request. If at any point in this Concurrent Review procedure a request for Authorization for continued stay is received and We determine that it is not Medically Necessary for the Member to receive continued hospitalization or hospitalization at the level of care requested, We will notify the Member and his Providers, in writing, that the request is denied and no additional days are Authorized.

(2) If We deny a Concurrent Review request or level of care request for Hospital Services, We will notify the Member, the Physician and the Hospital of the denial. If the Member elects to remain in the Hospital as an Inpatient thereafter, or at the same level of care, the Member will not be responsible for any charges unless the Member is notified of the financial responsibility by the Physician or Hospital in advance of incurring additional charges.

(3) Charges for non-Authorized days in the Hospital that the Member must pay are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

4. Authorization of Outpatient Services, Including Other Covered Services and Supplies

Certain services, supplies, and Prescription Drugs require Our Authorization before a Member receives the services, supplies, or Prescription Drugs. The Authorizations list is shown in the Member's Schedule of Benefits. The Member is responsible for making sure the Provider obtains all required prior Authorizations before the services, supplies, or Prescription Drugs are received. We may need the Member's Provider to submit medical or clinical information about the Member's condition. To obtain prior Authorizations, the Member's Provider should contact Our care management department at the telephone number shown on

the Schedule of Benefits, Our customer service department at the telephone number shown on the ID card, or follow the instructions in the Provider Manual, if available to the Provider or facility.

a. If a request for Authorization is denied by Us, the Outpatient services and supplies are not covered.

b. If a Provider fails to obtain Authorization for the Outpatient services and supplies which indicate no Benefit without written / prior Authorization on the prior Authorization list, the Outpatient services and supplies are not covered.

c. If Authorization is not requested prior to receiving Outpatient services and supplies requiring Authorization, We will have the right to determine if the services and supplies were Medically Necessary. If the services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider.

d. Additional amounts for which the Member is responsible because Authorization of Outpatient services and supplies was denied or not requested are considered non-covered and will not accrue to the Deductible Amount or Out-of-Pocket Amount.

5. Cancer Patient's Right to Prompt Coverage Act

   The requirements set forth in La. R.S. 22:1016.12 through La. R.S. 22:1016.16, the Cancer Patient's Right to Prompt Coverage Act related to prior authorization (as defined therein) and coverage of services for the diagnoses and treatment of cancer will be followed.

6. Utilization Review Standards Required by Louisiana Law

   The requirements set forth in La. R.S. 22:1260.41 through La. R.S. 22:1260.48 related to utilization review, including to prior authorization (as defined therein), will be followed.

B. Disease Management

1. Qualification - The Member may qualify for Disease Management programs, at Our discretion, based on various criteria, including a diagnosis of chronic illness, severity, and proposed or rendered treatment. The program seeks to identify candidates as early as possible. Self-management techniques are reinforced and a personal nurse is assigned. The Member, Physicians and caregivers may be included in all phases of the disease management program. The disease management nurse may also refer members to community resources for further support and management.

2. Disease Management Benefits - Blue Cross Blue Shield of Louisiana's Disease Management programs are committed to improving the quality of care for its Members as well as decreasing healthcare costs in populations with a chronic disease. The nurse works with Members to help them learn the self-care techniques they will need in order to manage their chronic disease, establish realistic goals for life style modification, and improve adherence to their Physician prescribed treatment plan. Blue Cross and Blue Shield of Louisiana is dedicated to supporting the Physician's efforts in improving the health status and well-being of the Member.

C. Case Mangement

1. The Member may qualify for Case Management Services, at Our discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits.

2. The role of Case Management is to service the Member by assessing, facilitating, planning and advocating for health needs on an individual basis. The client population who benefits from Case Management is broad and consists of several groups, including those in an acute phase of illness or those with a chronic condition.

3. Our determination that a particular Member's medical condition renders the Member a suitable candidate for Case Management services will not obligate Us to make the same or similar determination for the Member or for any other Member: The provision of Case Management services to one Member will not entitle the Member or any other Member to Case Management services or be construed as a waiver of Our right to administer and enforce this Contract in accordance with its express terms.

4. Unless expressly agreed upon by the Us, all terms and conditions of this Contract, including but not limited to maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Member is receiving Case Management services.

5. The Member's Case Management services will be terminated upon any of the following occurrences:

    a. We determine in Our sole discretion, that a Member is no longer a suitable candidate for the Case Management services or that the Case Management services are no longer necessary.

    b. The short and long-term goals established in the Case Management plan have been achieved, or the Member elects not to participate in the Case Management plan.

D. Alternative Benefits

1. The Member may qualify for Alternative Benefits, at the Company's discretion, based on various criteria, including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates as early as possible and to work with patients, their Physicians and families, and other community resources to assess treatment alternatives and available Benefits when it is determined to be beneficial to the Member and to the Company.

2. The Company's determination that a particular Member's medical condition renders the Member a suitable candidate for Alternative Benefits will not obligate the Company to make the same or similar determination for any other Member; nor will the provision of Alternative Benefits to a Member entitle any other Member to Alternative Benefits or be construed as a waiver of the Company's right to administer and enforce this Benefit Plan in accordance with its express terms.

3. Unless expressly agreed upon by the Company, all terms and conditions of this Benefit Plan, including, but not limited to, maximum Benefit limitations and all other limitations and exclusions, will be and shall remain in full force and effect if a Member is receiving Alternative Benefits.

4. Alternative Benefits provided under the Article are provided in lieu of the Benefits to which the Member is entitled under this Benefit Plan and accrue to the maximum Benefit limitations under this Benefit Plan.

5. The Member's Alternative Benefits will be terminated upon any of the following occurrences:

    a. We determine, in Our sole discretion, that the Member is no longer a suitable candidate for the Alternative Benefits or that the Alternative Benefits are no longer necessary.

    b. The Member receives care, treatment, services, or supplies for the medical condition that are excluded under this Benefit Plan, and that are not specified as Alternative Benefits approved by Us.

ARTICLE XX. LIMITATIONS AND EXCLUSIONS

A. Benefits for conditions, services, Surgery, supplies and treatment for that are not covered under this Benefit Plan are excluded.

B. If a Member has Complications from excluded conditions, Surgery, or treatments; Benefits for such conditions, services, Surgery, supplies and treatment are excluded.

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

D. Unless otherwise shown as covered on the Schedule of Benefits, the following are excluded:

1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary, as defined in this policy. The fact that a Physician or other Provider prescribes, orders, recommends or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.

2. Any charges exceeding the Allowable Charge.

3. Incremental nursing charges which are in addition to the Hospital's standard charge for Bed, Board and General Nursing Service; charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience; or Bed, Board and General Nursing Service in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Benefits are excluded for services, Surgery, supplies, treatment, or expenses:

   a. other than those specifically listed as covered by this Benefit Plan or for which a Member has no obligation to pay, or for which no charge or a lesser charge would be made if a Member had no health insurance coverage. Benefits are available when Covered Services are rendered at medical facilities owned and operated by the State of Louisiana or any of its political subdivisions;

   b. rendered or furnished before the Member's Effective Date or after Member's coverage terminates, except as follows: Medical Benefits in connection with an Admission will be provided for an Admission in progress on the date a Member's coverage under this Benefit Plan ends, until the end of that Admission or until a Member has reached any Benefit limitations set in this Benefit Plan, whichever occurs first;

   c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his license;

   d. to the extent payment has been made or is available under any other contract issued by Blue Cross and Blue Shield of Louisiana or any Blue Cross or Blue Shield Company, or to the extent provided for under any other contract, except as allowed by law, and except for limited Benefit policies;

   e. paid or payable under Medicare Parts A or B when a Member has Medicare, except when Medicare Secondary Payer provisions apply;

   f. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures;

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

h. rendered, prescribed, or otherwise provided by a Provider who is the Member, the Member's Spouse, child, stepchild, parent, stepparent or grandparent;

i. for telephone calls, video communication, text messaging, e-mail messaging, instant messaging, or patient portal communications between You and Your Provider unless specifically stated as covered under the Telehealth Services Benefit; for services billed with Telehealth codes not suitable for the setting in which the services are provided; for Telehealth Services not permitted by Us; and for Telehealth Services rendered by Providers not permitted by Us;

j. for Remote Patient Therapy Services and devices unless the results are specifically required for a medical treatment decision for a Member or as required by law;

k. for failure to keep a scheduled visit, completion of a Claim form, to obtain medical records of information required to adjudicate a Claim, or for access to or enrollment in or with any Provider;

l. for services performed in the home unless the services meet the definition of Home Health Care, or otherwise covered specifically in this policy, or are approved by Us;

m. for any incidental procedure, unbundled procedure, or mutually exclusive procedure, except as described in this Benefit Plan; or

n. for paternity tests and test performed for legal purposes.

5. Benefits are excluded for services in the following categories:

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

b. those for injuries or illnesses found by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;

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

d. those occurring as a result of a Member's commission or attempted commission of a felony; This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Member for illness or bodily injury otherwise covered under this Contract when the illness or bodily injury arises out of an act of domestic violence or a medical condition, including both physical and mental health conditions, or for Emergency Medical Services.

e. for treatment of any Member detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.

6. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, surgery, supplies, treatment, or expenses in connection with or related to, or Complications from the following:

a. rhinoplasty;

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

c. gynecomastia;

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

e. implantation, removal and/or re-implantation of breast implants and services, illnesses, conditions, Complications and/or treatment in relation to or as a result of breast implants, except for breast reconstructive services as specifically provided in this Contract. When a Medically Necessary mastectomy is otherwise covered under this Contract, removal of breast implants that were originally implanted during a Cosmetic Surgery and/or for cosmetic purposes is only covered when removal constitutes an incidental service under the Medical and Surgical Benefits Article of this Contract. As an incidental service, the removal of breast implants, capsulectomy, and other services, treatments, or procedures determined by Us to be an incidental service may not be billed separately;

f. implantation, removal and/or re-implantation of penile prosthesis and services, illnesses, conditions, Complications and/or treatment in relation to or as a result of penile prosthesis;

g. diastasis recti;

h. biofeedback;

i. lifestyle/habit changing clinics and/or programs, except those the law requires Us to cover or those We offer, endorse, approve, or promote, as part of Your healthcare coverage under this Benefit Plan. Some of these programs may be offered as value-added services and may be subject to minimal additional cost. If clinically eligible to participate, You voluntarily choose whether to participate in the programs.

j. Wilderness camp/programs except when provided by a qualified Residential Treatment Center and approved by Us as Medically Necessary for the treatment of mental health conditions or substance use disorders;

k. treatment related to erectile or sexual dysfunctions, low sexual desire disorder or other sexual inadequacies.

l. industrial testing or self-help programs including, but not limited to stress management programs, work hardening programs and/or functional capacity evaluations; driving evaluations, etc. except services required to be covered by law;

m. recreational therapy;

n. primarily to enhance athletic abilities; and/or

o. Inpatient pain rehabilitation and Inpatient pain control programs.

7. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses related to:

a. eyeglasses or contact lenses (except for the initial pair and fitting of eyeglasses or contact lenses required following cataract Surgery), unless shown as covered on the Schedule of Benefits;

b. eye exercises, visual training, or orthoptics;

c. hearing aids or for examinations for the prescribing or fitting of hearing aids, except as specified in this Benefit Plan;

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

e. the correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or

f. visual therapy.

8. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment or expenses related to:

   a. any costs of donating an organ or tissue for transplant when a Member is a donor except as provided in this Benefit Plan;

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

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

   d. bone marrow transplants and stem cell rescue (autologous and allogeneic) are not covered, except as provided in this Benefit Plan.

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

9. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any of the following, except as specifically provided for in this Benefit Plan or on the Schedule of Benefits:

   a. weight reduction programs;

   b. bariatric surgery procedures including, but not limited to:

      (1) Roux-en-Y gastric bypass;

      (2) Laparoscopic adjustable gastric banding;

      (3) Sleeve gastrectomy;

      (4) Duodenal switch with biliopancreatic diversion;

   c. removal of excess fat or skin, regardless of Medical Necessity, or services at a health spa or similar facility; or

   d. obesity or morbid obesity, regardless of Medical Necessity, except as required by law.

10. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Food Products or prescription donor human breast milk as described in this Benefit Plan.

11. Benefits are excluded for Prescription Drugs that We determine are not Medically Necessary for the treatment of illness or injury.

    The following are also excluded unless shown as covered on the Schedule of Benefits:

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

    b. medications for obesity, weight loss, weight management, or weight maintenance (e.g., Contrave®, Qsymia®, Saxenda®, Wegovy™);

c. any medication not proven effective in general medical practice;

d. Investigational drugs and drugs used other than for the FDA approved indication along with all Medically Necessary services associated with the administration of the drug, except drugs that are not FDA approved for a particular indication but that are recognized for treatment of the covered indication in a standard reference compendia or as shown in the results of controlled clinical studies published in at least two peer reviewed national professional medical or the drug is expected to provide a similar clinical outcome for the covered indication as those included in nationally accepted standards of medical practice as determined by Us;

e. fertility drugs;

f. nutritional or dietary supplements, or herbal supplements and treatments, except those required to be covered by the United States Preventive Services Task Force preventive services recommendations. Low Protein Food Products and prescription donor human breast milk are covered as described in this Benefit Plan;

g. prescription vitamins not listed as covered in the Prescription Drug Formulary (including but not limited to Enlyte).

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

i. selected Prescription Drugs for which there is an OTC-equivalent or for which a similar alternative exists as an OTC medication;

j. refills in excess of the number specified by the Physician or the dispensing limitation described in this Benefit Plan, or a refill prior to seventy-five percent (75%) of day supply used, or any refills dispensed more than one (1) year after the date of the Physician's original prescription;

k. compounded drugs that exhibit any of the following characteristics: 1) are similar to a commercially available product; 2) whose principal ingredient(s) are being used for an indication for which there is no FDA approval; 3) whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling (e.g., a drug approved for oral use being administered topically); 4) compounded drugs that contain drug products or components of such drug products that have been withdrawn or removed from the market for reasons of safety; or 5) compounded prescriptions whose only ingredients do not require a prescription;

l. Selected Prescription drug products that contain more than one (1) active ingredient (sometimes known as "combination drugs");

m. Prescription Drug products that include or are packaged with a non-Prescription Drug product;

n. Prescription Drug compounding kits;

o. selected Prescription Drug products that are packaged in a way that contains more than one (1) Prescription Drug;

p. selected Prescription Drug products with multiple therapeutic alternatives, which may be available in a greater or lesser strength or different dosage form (e.g., tablet, capsule, liquid, suspension, extended release, tamper resistant);

q. Prescription Drug products that contain marijuana, including medical marijuana;

r. Prescription Drugs filled prior to the Member's Effective Date or after a Member's coverage ends;

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

t. Prescription Drugs, equipment or substances to treat sexual or erectile dysfunction (e.g., Viagra®, Cialis®, Levitra®), low sexual desire disorder (Addyi®) or other sexual inadequacies;

u. Medication, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner;

v. growth hormone therapy, except for chronic renal insufficiency, AIDS wasting, Turner's Syndrome, Prader-Willi syndrome, Noonan Syndrome, wound healing in burn patients, growth delay in patients with severe burns, short bowel syndrome, short stature homeobox-containing gene (SHOX) deficiency, or growth hormone deficiency when a Physician confirms the growth hormone deficiency with abnormal provocative stimulation testing; or

w. Prescription Drugs for and/or treatment of idiopathic short stature; or

x. Prescription Drug coverage for Controlled Dangerous Substances may be limited or excluded when Controlled Dangerous Substances have been prescribed by multiple prescribers on a concurrent basis, where a prescriber agrees prescriptions were obtained through Member misrepresentation to that prescriber. Limitations may include, but are not confined to requiring future Controlled Dangerous Substances to be obtained from only one prescriber and one pharmacy.

y. topically applied prescription drug preparations that are approved by the FDA as medical devices.

z. Prescription Drugs approved for self-administration (e.g., oral or self-injectable drugs) are excluded when obtained from a Physician or other Provider unless the Provider is contracted with Our PBM.

aa. Covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include but are not limited to intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration as determined by Blue Cross and Blue Shield of Louisiana are covered under the medical Benefit and excluded under the pharmacy Benefit.

bb. Sales tax or interest including sales tax on Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the Member's Coinsurance and Our financial responsibility. We will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the Member's Copayment, in which case, the Member must pay the Prescription Drug cost and sales tax.

12. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for personal comfort, personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, exercise equipment, personal fitness equipment, or alterations to a Member's home or vehicle.

13. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for palliative or cosmetic care or treatment of the foot; supportive devices of the foot; and treatment of flat feet; except for Medically Necessary Surgery.

14. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for routine foot care, except as specifically provided in this Benefit Plan.

15. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any abortions other than to save the life of the mother.

16. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies related to the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote

intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. Even if fertile, these procedures are not available for Benefits. This exclusion shall not apply to services covered under the Fertility Preservation Services section of this plan.

17. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, supplies or treatment related to artificial means of Pregnancy including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, and drug or hormonal therapy administered as part of the treatment. This exclusion shall not apply to services covered under the Fertility Preservation Services section of this plan.

18. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for prenatal and postnatal services or supplies of a Gestational Carrier including, but not limited to, Hospital, Surgical, Mental Health, pharmacy or medical services.

19. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services.

20. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Cosmetic Surgery, piercings, procedures, services, supplies or treatment for cosmetic purposes, unless required for Congenital Anomaly or Mastectomy. Complications resulting from any of these items or any other non-covered items are excluded.

21. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Dental Care and Treatment and dental appliances except as specifically provided in this Benefit Plan under Oral Surgery Benefits and Pediatric Dental Care Benefits. This exclusion does not apply to Cleft Lip and Cleft Palate.

22. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for diagnosis, treatment, or surgery of dentofacial anomalies including, but not limited to, malocclusion, Temporomandibular Joint (TMJ) Disorder, hyperplasia or hypoplasia of the mandible and/or maxilla, and any orthognathic condition. This exclusion does not apply to Cleft Lip and Cleft Palate.

23. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical exams and/or diagnostic tests for routine or periodic physical examinations, screening examinations and immunizations, including occupational, recreational, camp or school required examinations, except as specifically provided in this Benefit Plan.

24. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for travel expenses of any kind or type other than covered Ambulance Services to the closest Hospital equipped to adequately treat your condition, except as specifically provided in this Benefit Plan, or as approved by Us.

25. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Repatriation of remains from an international location back to the United States is not covered. Private or commercial air or sea transportation is not covered. Members traveling overseas should consider purchasing a travel insurance policy that covers Repatriation to your home country and air/sea travel when ambulance is not required.

26. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for educational services and supplies, training or re-training for a vocation, or the diagnosis, testing, or treatment for remedial reading, dyslexia and other learning disabilities. This includes Applied Behavior Analysis services that are not habilitative treatment and specifically target academic and/or educational goals; and para-professional or shadowing services utilized as maintenance and/or Custodial Care to support academic learning opportunities in a classroom setting. This exclusion for educational services and supplies does not apply to training and education for diabetes or any United States Preventive Services Task Force recommendations that are required to be covered by law.

27. Benefits are excluded for Applied Behavior Analysis that the Company has determined is not Medically Necessary. The following is also excluded: Applied Behavior Analysis rendered by a Provider that has not been certified as an assistant behavior analyst or licensed as a behavior analyst by the Louisiana Behavior

Analyst Board or the appropriate licensing agency, if within another state. Applied Behavior Analysis is not covered for conditions other than Autism Spectrum Disorders.

28. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for admission to a Hospital primarily for Diagnostic Services, which could have been provided safely and adequately in some other setting, e.g., Outpatient department of a Hospital or Physician's office.

29. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Custodial Care, nursing home care, assisted living facility care or custodial home care, regardless of the level of care required or provided. This exclusion for Custodial Care does not apply to Habilitative Care services that the law requires Us to cover. This exclusion for Custodial Care applies to Claims for Private Duty Nursing Services that are determined by Us to be Custodial Care.

30. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for Hospital charges for a well newborn.

31. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, parental counseling and employment counseling. This exclusion does not apply to counseling services required to be covered for Preventive or Wellness Care or when required by law.

32. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for medical and Surgical treatment for snoring in the absence of obstructive sleep apnea, including laser assisted uvulopalatoplasty (LAUP).

33. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services, Surgery, supplies, treatment, or expenses of a covered Member related to:

    a. Genetic testing, unless the results are specifically required for a medical treatment decision on the Member or as required by law;

    b. Pre-implantation genetic diagnosis;

    c. Preconception carrier screening; and

    d. Prenatal carrier screening except screenings for cystic fibrosis.

34. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for reversal of a voluntary sterilization procedure.

35. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Us. Portable defibrillators are not covered. Implantable defibrillators and wearable defibrillators are covered when Authorized by Us.

36. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Benefits are excluded for services or supplies for the prophylactic storage of cord blood.

37. **REGARDLESS OF CLAIMS OF MEDICAL NECESSITY,** Benefits are excluded for Mental Health services or substance use disorder services delivered through the Psychiatric Collaborative Care Model when used to treat a condition other than an approved behavioral health diagnosis.

38. **REGARDLESS OF CLAIM OF MEDICAL NECESSITY,** Virtual reality services, supplies, technologies, treatment, devices, or expenses related thereto no matter the setting in which virtual reality is used, including, but not limited to, Surgery.

ARTICLE XXI. CONTINUATION OF COVERAGE RIGHTS

A. Surviving Spouse Continuation

1. If eligibility for Group coverage ceases upon the death of the Subscriber, a surviving Spouse covered as a Dependent who is fifty (50) years of age or older, has ninety (90) days from the date of the Subscriber's death to notify the Company of the election to continue the same coverage, and if already covered, for any Dependents.

    a. Coverage is automatic during the ninety (90) day election period. Premium is owed for this coverage. If continuation is not chosen, or if premium is not received for the ninety (90) days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.

    b. If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Premium is owed from the last date for which premium has been paid. No physical exams are required. Premium for continuing coverage will not exceed the premium assessed for each Subscriber by class of coverage under the Group contract.

2. The University will be responsible for notifying the Spouse of the right to continue and for billing and collection of premium. However, if We have been furnished with the home address of the surviving Spouse at the time of death and have been notified by the University in an acceptable manner of the death of the Subscriber, We will notify the surviving Spouse of the right to continue. The Group will remain responsible for billing and collection of premium.

3. Coverage continues, as long as premium is paid timely, until the earliest of:

    a. the date premium is due and is not paid on a timely basis;

    b. the date the surviving Spouse or a Dependent becomes eligible for Medicare;

    c. the date the surviving Spouse or a Dependent becomes eligible to participate in another group health plan;

    d. the date the surviving Spouse remarries or dies;

    e. the date this Group Benefit Plan ends; or

    f. the date a Dependent is no longer eligible.

B. COBRA Continuation

There are no provisions in the Plan to provide COBRA coverage to students who graduate or withdraw from school.

EXAMPLE:

Mary receives her M.D. degree on December 15, her student health plan coverage ends on December 30. She begins her residency on January 1 and her insurance through her residency begins on February 1. Mary will have to obtain coverage for the month of January until her new plan is effective.

Neither We, nor the University offers COBRA coverage because it is only required by law for employee health insurance plans.

ARTICLE XXII. GENERAL PROVISIONS – UNIVERSITY/POLICYHOLDER AND MEMBERS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE UNIVERSITY/POLICYHOLDER, AND ALL MEMBERS.

THE UNIVERSITY ENTERS INTO THIS BENEFIT PLAN ON BEHALF OF THE ELIGIBLE INDIVIDUALS ENROLLING UNDER THIS BENEFIT PLAN. ACCEPTANCE OF THIS BENEFIT PLAN BY THE UNIVERSITY IS ACCEPTANCE BY AND BINDING UPON THOSE WHO ENROLL AS SUBSCRIBERS AND DEPENDENTS.

A. This Benefit Plan

1. This Benefit Plan, including the University's application for coverage, and any Application Benefit Change Forms, expressing the entire money and other consideration therefore, Schedule of Benefits, and any attached amendments or endorsements, constitutes the entire contract between the parties.

2. Except as specifically provided herein, this Benefit Plan will not make Us liable or responsible for any duty or obligation that is imposed on the University by federal or state law or regulations. The University will be the administrator of this Benefit Plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those that We specifically undertake herein. To the extent this Benefit Plan provides Benefits for the treatment of certain injuries, exclusions to those covered Benefits do not apply to an extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Member for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions); or for Emergency Medical Services. The University will indemnify and hold Us harmless in the event we incur any liability as a result of the University's failure to comply with any law or regulation.

3. The Company will not be liable for, or on account of, any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with the Member's care or treatment.

4. The Company has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan. Members that disagree with the Company's determination may pursue any applicable procedures available under the terms of this Benefit Plan and the law.

5. The Company shall have the right to enter into any contractual agreements with subcontractors, healthcare Providers, or other third-parties relative to this Benefit Plan. Any of the functions to be performed by Us under this Benefit Plan may be performed by Us or any of Our subsidiaries, affiliates, subcontractors, or designees.

B. Section 1557 Grievance Procedure

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

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

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability, You may file a grievance under this procedure. It is against the law for Blue Cross Blue Shield of Louisiana to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

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

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

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

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

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

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

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

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

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

C. Benefit Plan Changes

Subject to all applicable laws, We reserve the right to modify the terms of this Benefit Plan upon not less than sixty (60) days notice to the University. No change or waiver of any Benefit Plan provision will be effective until approved by Our chief executive officer or his delegate.

D. Identification Cards and Benefit Plan

We will prepare an identification (ID) card for each Subscriber. We will issue a Benefit Plan to the University and print a sufficient number of copies of the Benefit Plan for University's Subscribers. At the direction of University, We will either deliver all materials to the University for University's distribution to the Subscribers, or We will deliver the Subscriber materials directly to each Subscriber. The Subscriber's copy of the Benefit Plan shall serve as his certificate of coverage. Unless otherwise agreed between the University and Us, the University has the sole responsibility for distributing all such documents to Subscribers.

E. Benefits to Which Members Are Entitled

1. Our liability is limited to the Benefits specified in this Benefit Plan.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

3. Continuity of care of healthcare services.

   a. When We end a contractual agreement with a Provider, if You have begun a course of treatment with that Provider, We will notify You that We have removed the Provider from the Preferred Care Network. If You are a continuing care patient, You can continue receiving Covered Services until the earlier of the completion of the course of treatment or 90 days after We notify You that the Provider has left the Preferred Care Network.

   b. A continuing care patient is one who is:

      (1) Undergoing a course of treatment for a Serious and Complex Condition;

      (2) Undergoing a course of institutional or Inpatient care;

      (3) Scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care;

      (4) Pregnant and undergoing a course of treatment for the pregnancy; or

      (5) Terminally ill, which means the medical prognosis is a life expectancy of 6 months or less, and receiving treatment for the terminal illness from the Provider.

   c. The provisions of continuity of care do not apply if one of the following occurs:

      (1) The reason for termination of a Provider's contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.

      (2) The reason for termination of a Provider's contractual agreement is as a result of fraud.

      (3) You voluntarily choose to change Providers.

      (4) You move outside of the geographic Service Area of the Provider or the Preferred Care Network.

      (5) Your condition does not meet the requirements to be deemed a Serious and Complex Condition.

F. Notice of Member Eligibility - University's Personnel Data

1. The University is solely responsible for furnishing the information that We require for purposes of enrolling Members of the University under this Benefit Plan, processing terminations, and effecting changes in family

and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate the Company to provide Benefits under this Benefit Plan.

2. All notification of membership or coverage changes must be on forms that We approve and include all information required by the Company to effect changes.

3. The University must notify Our membership & billing department of a Member's termination of coverage by completing a cancellation form (or such other form of notification acceptable to Us) and submitting it to Our offices no later than within the next billing cycle immediately following the billing cycle in which the Member or any of the Member's Dependents is terminated from the University or eligibility for coverage ends (or any other period described on the Schedule of Benefits). The Company is under no obligation to refund any premium paid by University or any Member if payment was made to the Company due to University's failure to timely notify the Company of a Member's or his Dependent's termination of coverage.

4. Requests for termination of coverage that are submitted after the period provided above will only be honored prospectively after the date of receipt and the University will be responsible to pay all corresponding premiums until the effective date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply. Whenever the University submits a request to the Company to terminate a Member's coverage or that of any of a Member's Dependents, the University will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the date on which the University desires the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date.

5. The University warrants the accuracy of the information it transmits to Us and understands that We will rely on this information. The University agrees to supply or allow inspection of personnel records to verify eligibility as requested by Us.

6. The University further agrees to indemnify Us for all expenses We may incur because of the University's failure to transmit correct information in the time-period that We require. Indemnification includes but is not limited to, Claims payments made on behalf of individuals that are not eligible for Benefits. Alternatively, the Company at its sole option may hold the University responsible for all premium payments for Members who are not timely cancelled from coverage due to the University's failure to timely notify the Company of terminations or changes in eligibility.

G. Termination of a Member's Coverage

1. The Company may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this policy. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this coverage. Any information intentionally omitted from the application or enrollment form, as to any proposed Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the Effective date of coverage or terminated within three (3) years of the Member's Effective Date, for fraud or intentional misrepresentation of material fact. The Company will give the Member sixty (60) days advance written notice prior to rescinding or terminating coverage under this section. If You enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact.

2. Unless Continuation of Coverage is available and selected as provided in this Benefit Plan, a Member's coverage terminates as provided below:

   a. The Subscriber's coverage and that of all his Dependents automatically, and without notice, terminates at the end of the billing cycle in which the Subscriber ceases to be eligible.

   b. The Subscriber has an obligation to notify Us, within 15 days, when Dependents die or need to be taken off the Contract for any reason. We will re-calculate premiums so the Subscriber pays the proper

amount. No refunds will be made to the Subscriber if the Subscriber fails to give timely notice when a Dependent ceases to be eligible to keep coverage or when a Dependent's coverage should have been terminated.

c. The coverage of the Subscriber's Spouse will terminate automatically and without notice at the end of the billing cycle for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage is rendered. The Subscriber has an obligation to notify Us, within 15 days, after a final decree of divorce or other legal termination of marriage is rendered.

d. The coverage of a Dependent will terminate automatically, and without notice, at the end of the billing cycle in which the Dependent ceases to be an eligible Dependent, if premiums have been paid through that period.

e. Upon the death of a Subscriber, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the billing cycle in which the death occurred if premiums have been paid through that period. However, a surviving Spouse or Dependent may elect continuation of coverage as described elsewhere in this Benefit Plan.

3. In the event the University cancels this Benefit Plan or this Benefit Plan is terminated by Us for nonpayment of the appropriate payment when due or for the University's failure to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to terminate all rights of the Member to Benefits under the terms of this Benefit Plan as of the effective date of such cancellation or termination. The University shall have the obligation to notify its Members, participants, and beneficiaries of such cancellation or termination. We shall have no such obligation of notification at the Member level.

4. However, in the event of termination under the provisions of paragraphs a., b., c. or d. above, if the Member is an Inpatient in a Hospital on the date of termination, medical Benefits in connection with the Admission for that patient will terminate at the end of that Admission, or upon reaching any Benefit limitations set in this Benefit Plan, whichever occurs first.

5. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Member for Covered Services rendered after the date of termination of a Member's coverage.

6. We reserve the right to automatically change the Subscriber's class of coverage to reflect when no more children or grandchildren are covered under this Benefit Plan.

7. Cancellation will be effective at midnight on the last day of the billing cycle. Billing cycles are from the first to the end of the month.

8. When the University's coverage ends because the plan ceases to exist, members may be eligible for individual coverage through the Federal Healthcare Marketplace [www.healthcare.gov].

H. Filing Claims

1. You must file all Claims within ninety (90) days from the date services were rendered, unless it is not reasonably possible to do so. In no event may any Claim be filed later than fifteen (15) months from the date services were rendered.

2. Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Member. However, if the Member must file a Claim to access their Prescription Drug Benefit, the Member must use the Prescription Drug Claim Form. The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Our Pharmacy Benefit Manager.

I. Time Limit for Legal Action

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

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

J. Release of Information

We may request that the Member or the Provider furnish certain information relating to the Member's Claim for Benefits. We will hold such information, records, or copies of records as confidential except where in Our discretion the same should be disclosed.

K. Assignment

1. The Member's rights and Benefits payable under this Benefit Plan are personal to the Member and may not be assigned in whole or in part by the Member. We will recognize assignments of Benefits to both Hospitals and the Provider if this Benefit Plan is subject to La. R.S. 40:2010. If both this Benefit Plan and the Provider are not subject to La. R.S. 40:2010, We will not recognize assignments or attempted assignments of Benefits. Nothing contained in the written description of health coverage shall be construed to make the health plan or Us liable to any third-party to whom the Member may be liable for the cost of medical care, treatment, or services.

2. We reserve the right to pay Preferred Care Network Providers, and/or Providers in the Blue Cross and Blue Shield of Louisiana Participating Provider Network directly instead of paying the Member.

L. Member/Provider Relationship

1. The choice of a Provider is solely the Members.

2. We and all Network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. Blue Cross and Blue Shield of Louisiana does not render Covered Services but only makes payment for Covered Services that the Member receives. We are not liable for any act or omission of any Provider, or for any Claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or in any Network Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to the Member.

3. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

M. Applicable Law and Conforming Policy

This Benefit Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana except when preempted by federal law. This Benefit Plan shall conform to the Essential Health Benefits package and requirements. This Benefit Plan is not subject to regulation by any state other than the State of Louisiana. If any provision of this Benefit Plan is in conflict with any applicable law of the State of Louisiana or the United States of America, the Benefit Plan shall be automatically amended to meet the minimum requirements of the law. Any legal action filed against the Plan must be filed in the appropriate court in the State of Louisiana.

N. Notice

Any notice required under this Benefit Plan must be in writing. Notice given to the University will be sent to the University's address stated in the Application for University Coverage. Notice given to Us will be sent to Our address stated in this Benefit Plan. Any notice required to be given will be considered delivered when deposited in the United States mail, postage prepaid, addressed to the Member at his address as the same appears on Our records, or to the University at the address as the same appears on Our records. We, the University, or the Member may, by written notice, indicate a new address for giving notice.

O. Job-Related Injury or Illness

The University must report to the appropriate federal or state governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any federal or state laws and/or related programs. This Benefit Plan excludes Benefits for any services rendered as a result of occupational disease or injury compensable under any federal or state workers' compensation laws and/or any related programs including, but not limited to, the Jones Act, Federal Employers Liability Act, Federal Employees Compensation Act, Longshore and Harbor Workers' Compensation Act, Black Lung Benefits Act, Energy Employees Occupational Illness Compensation Program, and Title 23 of the Louisiana Revised Statutes. In the event that We initially extend Benefits and a compensation carrier, employer, governmental agency or program, insurer, or any other entity makes any type of settlement with the Member, with any person entitled to receive settlement when the Member dies, or if the Member's injury or illness is found to be compensable under federal or state workers' compensation laws or programs, the University or the Member must reimburse Us for Benefits extended or direct the compensation carrier, employer, governmental agency, or program, insurer, or any other entity to make such reimbursement. We will be entitled to such reimbursement even if the settlement does not mention or excludes payment for healthcare expenses.

P. Subrogation

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, We will be subrogated and will succeed to the Member's right for the recovery of the amount paid under this Benefit Plan against any person, organization, insurer or other carrier even where such insurer or carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits under this Benefit Plan will constitute subrogation. Our right to recover will be contingent on the Member's right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or a judgment following a trial. We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by the Member in pursuing recovery.

2. The Member will reimburse Us all amounts recovered by suit, settlement, or otherwise from any person, organization, insurer or other carrier, even where such carrier provides Benefits directly to a Member who is its insured,' to the extent of the Benefits provided or paid under this Benefit Plan. Our right to recover will be contingent on [Your] [the Member's] right to be fully compensated as determined by settlement of the parties in any claim for recovery or legal action, a ruling in a legal action by a court of competent jurisdiction, or judgment following a trial. We agree that We will be responsible for Our proportionate share of the reasonable attorney fees and costs actually paid by the Member in pursuing recovery.

3. The Member will take such action, furnish such information and assistance, and execute such papers as We may be required to facilitate enforcement of Our rights, and will take no action prejudicing Our rights and interest under this Benefit Plan. The Company and its designees have the right to obtain and review Your medical and billing records, if the Company determines in its sole discretion, that such records would be helpful in pursuing its right of subrogation and/or reimbursement.

4. The Member must notify Us of any Accidental Injury.

Q. Right of Recovery

Whenever any payment for Covered Services has been made by Us in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or whenever payment has been made in error by Us for non-Covered Services, We will have the right to recover such payment from the Member or, if applicable, the Provider. As an alternative, We reserve the right to deduct from any pending Claim for payment under this Benefit Plan any amounts that We are owed by the Member or the Provider.

R. Coverage in a Department of Veterans Affairs or Military Hospital

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from Us to the extent the veteran would be eligible for Benefits for such care or services from Us if the care or services had not been furnished by a department or agency of the United States. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

The United States will have the right to collect from Us the reasonable cost of healthcare services incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that the retiree or Dependent would be eligible to receive reimbursement or indemnification from Us if the retiree or Dependent were to incur such cost on his own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Coinsurance.

S. Dual Coverage and Coordination of Benefits (COB)

If a Member has this coverage in addition to other individual or group health coverage, We may coordinate Benefits between this Contract and the other coverage, as allowed by law. The Company, in its sole discretion, and as allowed by law, may terminate excess policies and return to the insured all premiums paid for any excess policies.

If a Member has this coverage in addition to Medicare, We will coordinate Benefits between this Contract and Medicare, as allowed by law.

When a Member has this coverage in addition to other group health coverage, Benefits under this Contract will be determined on a secondary basis after the group coverage. Whenever coordination of Benefits applies between this Contract and any other coverage, Benefits under this Contract and will be reduced so that no more than the full amount of the Allowable Charge is paid under all coverages for the same Claim or service.

If a Member has stand-alone coverage for dental or vision, Benefits besides the Benefits provided for under this Contract, the Benefits offered under the stand-alone coverage will be determined first. In no event shall the combined payment under multiple policies, including federal or state government plans, exceed one hundred percent of the Allowable Charge for the provided healthcare service.

1. Right to Receive and Release Needed Information

   Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield of Louisiana has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person. Blue Cross and Blue Shield of Louisiana need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Contract must give Blue Cross and Blue Shield of Louisiana any facts it needs to pay the Claim.

2. Facility of Payment

   A payment made under another plan may include an amount, which should have been paid under this Contract. Blue Cross and Blue Shield of Louisiana may pay that amount to the organization which made that payment. That amount will then be treated as though it were a Benefit paid under this Contract. To the extent such payments are made, they discharge Blue Cross and Blue Shield of Louisiana from further liability. The term “payment made” includes providing Benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any Benefits provided in the form of services.

T. Liability of Plan Affiliates

The University, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Us and the University, that We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of

independent Blue Cross and Blue Shield Plans, the "Association" permitting Us to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana, and that We are not contracting as the agent of the Association. The University, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Us and that no person, entity, or organization other than Us shall be held accountable or liable to the University for any of Our obligations to the University created under this agreement. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this agreement.

U. HIPAA Certificates of Creditable Coverage

We will issue a certificate of Creditable Coverage or similar document to an individual, if requested within twenty-four (24) months after coverage under this Contract ceases.

V. Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage

The Medicare Modernization Act (MMA) requires groups whose policies include Prescription Drug coverage to notify Medicare-eligible Members whether their Prescription Drug coverage is creditable, which is defined to mean that the coverage is expected to pay on average as much as the standard Medicare Part D Prescription Drug coverage. The types of coverage required to provide the notices are those listed at 42 CFR 423.56(b) and includes, but is not limited to, group health plans, individual health insurance coverage, and Medicare supplement plans. For these groups, there are two disclosure requirements:

1. The first disclosure requirement is to provide a written disclosure notice to all Medicare-eligible Members annually who are covered under its Prescription Drug plan, prior to October 15th each year and at various times as stated in the regulations, including to a Medicare-eligible Member when they join the Plan. This disclosure must be provided to Medicare-eligible active working Members and their Dependents, Medicare-eligible COBRA Members and their Dependents, Medicare-eligible disabled Members covered under its Prescription Drug plan and any Retirees and their Dependents. The MMA imposes a late enrollment penalty on Members who do not maintain creditable coverage for a period of 63 days or longer following their initial enrollment period for the Medicare Prescription Drug Benefit. Accordingly, this information is essential to a Member's decision whether to enroll in a Medicare Part D Prescription Drug plan.

   The Groups are responsible for sending the required notices. As a service to the Group and based upon enrollment data provide to Us by the Group, We shall provide, without charge, Medicare Part D Certificates of Creditable or Non-Creditable Prescription Drug Coverage to Medicare-eligible Members who have Prescription Drug coverage under this Benefit Plan at the following times, or as otherwise directed by law:

   a. prior to the Medicare Part D Annual Coordinated Election Period;

   b. prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D (age-in);

   c. prior to the Effective Date of coverage for new Medicare-eligible Members that join this Benefit Plan;

   d. whenever Prescription Drug coverage under this Benefit Plan ends or changes so that it is no longer creditable or it becomes creditable; and/or

   e. upon a Medicare Beneficiary's request.

2. The second disclosure requirement is for groups to complete the *Online Disclosure to CMS Form* to report the creditable coverage status of their Prescription Drug Plan. The Disclosure should be completed annually no later than 60 days from the beginning of a Plan Year (contract year, renewal year), within 30 days after termination of a Prescription Drug Plan, or within 30 days after any change in creditable coverage status. This requirement does not pertain to the Medicare beneficiaries for whom groups are receiving the Retiree Drug Subsidy (RDS).

   The Groups are responsible for the submission of the *Online Disclosure to CMS Form*.

W. Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

1. BlueCard® Program

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

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

   a. the billed charges for Your Covered Services;

   b. the negotiated price that the Host Blue makes available to Us; or

   c. an amount determined by applicable law.

   Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

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

2. Special Case: Value-Based Programs

   As an alternative to the BlueCard® Program, your Claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

   The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price made available to us by the Host Blue.

a. BlueCard® Program

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

b. Negotiated (non-BlueCard® Program) Arrangements

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

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

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

4. Non-Participating Providers Outside Our Service Area

a. Member Liability Calculation

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

b. Exceptions

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

5. Blue Cross Blue Shield Global® Core

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

For medical assistance services (including finding a doctor or Hospital) outside the BlueCard® service area, call:

Blue Cross Blue Shield Global® Core service center
24 hours a day, 7 days a week
1-800-810-BLUE
1-800-810-2583,

or call collect:

1-804-673-1177

Working with a medical professional, an assistance coordinator will arrange a Physician appointment or hospitalization, if necessary.

a. Inpatient Services

In most cases, if You contact the Blue Cross Blue Shield Global® Core service center for help and the Provider agrees to accept a guaranteed payment, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible Amount and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center. But, if the Provider does not agree to a guaranteed payment or You otherwise paid in full when You received services, You must submit a Claim to be reimbursed. You must contact Us for Authorization for non-Emergency Inpatient services, as explained in the Care Management Article and meet other requirements in Your Contract for services to be provided, including, but not limited to, receiving only Medically Necessary services.

b. Outpatient Services

If you go to Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area, typically You must pay in full when You receive a service. To be reimbursed, You must submit a Claim.

c. Exceptions

In situations where the Blue Cross Blue Shield Global® Core service center is unable to obtain a guaranteed payment for a Global® Core claim, We may use other payment methods to figure the payment We will make for the health care services that were delivered outside Our Service Area. Those other payment methods include, but are not limited to, billed charges for Covered Services, the payment We would make if the healthcare services had been obtained within Our Service Area, or a special negotiated payment to determine the amount We will pay for services from Non-Participating Providers. In these situations, You need to comply with the requirements of Your Contract and You may have to pay the difference between the amount that the Provider bills and the payment We will make for the Covered Services.

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

When You pay for Covered Services outside the BlueCard® Service Area, You must submit a Claim to obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core Claim form. Send the form with the Provider's itemized bills to the Blue Cross Blue Shield Global® Core service center at the address on the form.

Make sure to follow the instructions on the form. For a copy of the form, contact Us or the Blue Cross Blue Shield Global® Core service center, or go to **www.bcbsglobalcore.com**.

For help submitting Your Claim, call:

Blue Cross Blue Shield Global® Core service center
24 hours a day, 7 days a week
1-800-810-BLUE
1-800-810-2583,

or call collect:

X. Our Right to Offer Premium Incentives

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

1. Encouraging Members and/or policyholders to participate in quality programs;

2. Ensuring Members and/or policyholders are better able to afford Benefits packages;

3. Reducing and alleviating social determinants of health;

4. Reducing transition costs for Members and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;

5. Rewarding Members and/or policyholders for choosing lower cost, quality healthcare Providers;

6. Rewarding Members and/or policyholders for selecting lower cost, quality healthcare goods and products;

7. Rewarding Members and/or policyholders for utilizing digital and other paperless forms of communication of information, including but not limited to plan documents and materials; and

8. Reducing enrollment, technology, or administration costs of Members and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

ARTICLE XXIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Member is dissatisfied about the care or services he receives from Blue Cross and Blue Shield of Louisiana or one of Our Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

A Member may be dissatisfied about decisions We make regarding Covered Services. We consider an Appeal as the Member's request to change an Adverse Benefit Determination made by the Company.

Your Appeal rights are outlined below, after the Complaint and Grievance procedures. In addition to the Appeals rights, the Member's Provider is given an opportunity to speak with a Medical Director for an Informal Reconsideration of Our coverage decision when they concern Medical Necessity determinations.

We have expedited Appeals processes for situations where the time frame of the standard medical Appeals would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function.

A. Complaint, Grievance, and Informal Reconsideration Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Our Network Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

   A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Members may call customer service to register a Complaint. We will attempt to resolve a Member's Complaint at the time of their call.

   Medical Benefits: call Us at 1-800-599-2583 or 1-225-291-5370

   Pediatric Dental Care Benefits: call UCD at 1-866-445-5338

   Pediatric Vision Care Benefits: call Davis Vision at 1-888-343-3470.

2. To File a Formal Grievance

   A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Member does not feel their Complaint was adequately resolved or they 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, the Member may call Our customer service department.

   Send written Grievances to the applicable address listed below:

   <u>Medical Benefits:</u>

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

   <u>Pediatric Dental Care Benefits</u>

   Blue Cross and Blue Shield of Louisiana
   c/o United Concordia Dental
   P.O. Box 69420
   Harrisburg, PA 17106-9420

Blue Cross and Blue Shield of Louisiana
c/o Davis Vision
P.O. Box 791
Latham, NY 12110

A response will be mailed to the Member within thirty (30) business days of receipt of the Member's written Grievance.

3. Informal Reconsideration

An Informal Reconsideration is a request by telephone, made by and Authorized Provider on the Member's behalf, to speak to Our Medical Director or a peer reviewer 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 determinations that are requested within ten (10) days of the denial or Concurrent Review determinations. We will conduct an Informal Reconsideration within one (1) working day of Our receipt of the request.

B. Standard Appeals

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination for administrative Appeals and internal medical Appeals. Requests submitted to Us after one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination will not be considered.

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

If the Member has questions or needs assistance, the Member may call Our customer service department.

The Member has the right to appoint an authorized representative to speak on their behalf in their Appeals. An authorized representative is a person to whom the Member has given written consent to represent him in an internal or external review of an Adverse Benefit Determination. The authorized representative may be the Member's treating Provider if the Member appoints the Provider in writing.

We will determine if a Member's Appeal is an administrative Appeal or a medical Appeal.

The Member is 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 Adverse Benefit Determination.

We will provide the Member, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Benefit Determination.

1. Administrative Appeals

Administrative Appeals involve contractual issues, Rescissions, and Adverse Benefit Determinations which are not related to Medical Necessity, appropriateness, healthcare setting, level of care, effectiveness or treatment is determined to be experimental or investigational.

Administrative Appeals should be submitted in writing to:

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

Persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the administrative Appeal. If the administrative Appeal is overturned, We will reprocess the Member's Claim, if any. If the administrative Appeal is upheld, this decision will be considered final and binding.

The administrative Appeal decision will be mailed to the Member, his authorized representative, or a Provider Authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

Administrative Appeals have only one internal level of review and are not eligible for the External Appeal process with the exception of a Rescission.

2. Medical Appeals

Medical Appeals involve Adverse Benefit Determinations based on Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational and any related prospective or retrospective review determination.

We offer the Member two (2) standard levels of medical Appeals, including an internal review of the initial Adverse Benefit Determination, then an external review.

Medical Appeals should be submitted in writing to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

a. Internal Medical Appeals

A Physician or other healthcare professional; in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review and who is not subordinate to any previous decision-maker on the initial Adverse Benefit Determination, will review the internal Medical Necessity Appeal.

If the internal medical Appeal is overturned, We will reprocess the Member's Claim, if any. If the internal medical Appeal is upheld, We will inform the Member of their right to begin the External Appeal process if the Adverse Benefit Determination meets the criteria.

The internal medical Appeal decision will be mailed to the Member, his authorized representative, or a Provider Authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request; unless it is mutually agreed that an extension of time is warranted.

b. External Medical Appeal and Rescission

For medical Appeals and Rescission, the second level will be handled by an external Independent Review Organization (IRO) that is not affiliated with Us and randomly assigned by the Louisiana Department of Insurance.

A Member must exhaust all internal Appeal opportunities prior to requesting an External Appeal conducted by an Independent Review Organization.

If the Member disagrees with the internal medical Appeal decision or Rescission, a written request for an External Appeal must be submitted within four (4) months of receipt of the internal medical Appeal decision or Rescission to:

Blue Cross and Blue Shield of Louisiana
Medical Appeals
P. O. Box 98022
Baton Rouge, LA 70898-9022

Requests submitted to Us after four (4) months of receipt of the internal medical Appeal decision or Rescission will not be considered. You are required to sign the form included in the internal medical Appeal denial notice which authorizes release of medical records for review by the IRO. **Appeals submitted by your Provider will not be accepted without this form completed with Your signature.**

We will provide the IRO all pertinent information necessary to conduct the Appeal. The external review will be completed within forty-five (45) days of Our receipt of the External Appeal. The IRO will notify the Member, his authorized representative, or a Provider Authorized to act on the Member's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Member and Us for purposes of determining coverage under a health Contract. This Appeals process shall constitute your sole recourse in disputes concerning determinations of whether a health service or item is or was Medically Necessary or Investigational, except to the extent that other remedies are available under State or Federal law.

C. Expedited Appeals

The Expedited Appeal process is available for review of an Adverse Benefit Determination involving a situation where the time frame of the standard medical Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating Physician, the Member may experience pain that cannot be adequately controlled while awaiting a standard medical Appeal decision. An Expedited Appeal also includes requests concerning an Admission, availability of care, continued stay, or healthcare for a Member currently receiving Emergency Medical Services, under observation, or receiving Inpatient care.

An Expedited External Appeal is also available if the Adverse Benefit Determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is deemed experimental or Investigational; and the covered person's treating Physician certifies in writing that the recommended or requested healthcare service or treatment that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

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 Member, the Member's authorized representative, or a Provider Authorized to act on the Member's behalf. Requests for an Expedited Appeal may be verbal or written.

For verbal Expedited Appeals, call 1-800-376-7741 or 1-225-293-0625.

For written Expedited Appeals, fax 225-298-1837 or mail to:

Blue Cross and Blue Shield of Louisiana
Expedited Appeal - Medical Appeals
P.O. Box 98022
Baton Rouge, LA 70898-9022

1. Expedited Internal Medical Appeals

   In these cases, We will make a decision no later than seventy-two (72) hours of Our receipt of an Expedited internal medical Appeal request that meets the criteria for an Expedited Appeal. In any case where the Expedited internal medical Appeal process does not resolve a difference of opinion between Us and the Member or the Provider acting on behalf of the Member, the Appeal may be elevated to an Expedited External Appeal. If an Expedited internal medical Appeal does not meet the Expedited Appeal criteria or does not include the Physician attestation signature, the Appeal will follow the standard Appeal process timeframe.

2. Expedited External Medical Appeal

   An Expedited External medical Appeal is a request for immediate review, by an Independent Review Organization. The request may be simultaneously filed with a request for an Expedited internal medical Appeal, since the IRO assigned to conduct the Expedited External medical review will determine whether the request is eligible for an external review at the time of receipt. We will forward all pertinent information for Expedited External medical Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

   For all medical Appeals, the Office of Consumer Advocacy of the Department of Insurance is available to assist with the appeals process. You may contact the Commissioner of Insurance directly for assistance at:

   Commissioner of Insurance
   P. O. Box 94214
   Baton Rouge, LA 70804-9214
   1-225-342-5900 or 1-800-259-5300

D. No Surprises Act (NSA) Internal Appeals and External Appeals

The NSA added certain Member rights and protections that are eligible for internal Appeals and External Appeals. If a Member is dissatisfied about decisions We make regarding the Member's rights and protections added by the NSA, the Member may file an Appeal. Examples of the NSA Member rights and protections include the following:

1. Member cost-sharing and surprise billing protections for Emergency Medical Services;

2. Member cost-sharing and surprise billing protections related to care provided by Non-Network Providers at Network facilities;

3. Whether Members are in a condition to receive notice and provide Informed Consent to waive the NSA protections;

4. Whether a Claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to Member cost-sharing and surprise billing; and

5. Continuity of care.

The Member is encouraged to, and should, provide Us with all available information to help Us completely evaluate the NSA Appeal such as written comments, documents, records, and other information.

We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the determination that is the subject of the NSA appeal.

The Member has the right to appoint an authorized representative for NSA appeals. An authorized representative is a person to whom the Member has given written consent to represent the Member in an

internal Appeal or External Appeal. The authorized representative may be the Member's treating Provider if the Member appoints the Provider in writing.

1. NSA Internal Appeals

   If a Member believes that We have not complied with the surprise billing and cost-sharing protections or with continuity of care of the NSA, a written request for review must be submitted within one hundred eighty (180) days of the NSA-related Adverse Benefit Determination. Requests submitted to Us after one hundred eighty (180) days of the NSA-related Adverse Benefit Determination will not be considered.

   The NSA internal Appeals request should be submitted in writing to:

   Blue Cross and Blue Shield of Louisiana

   Appeals/Grievances Department

   P.O. Box 98045

   Baton Rouge, LA 70898-9045

   If a Member has questions or needs assistance, the Member may call Our customer service department at the number on the ID card.

   We will investigate the Member's concerns. If the NSA internal Appeal is overturned, We will reprocess the Member's Claim, if applicable. If the NSA internal Appeal is upheld, We will inform the Member of the right to begin the NSA External Appeal process.

   The NSA internal Appeal decision will be mailed to the Member, the Member's authorized representative, or a Provider authorized to act on the Member's behalf, within thirty (30) days of receipt of the Member's request, unless it is mutually agreed that an extension of time is warranted.

2. NSA External Appeals

   If a Member disagrees with the NSA internal Appeal decision, a written request for an NSA External Appeal must be submitted within four (4) months of receipt of the NSA internal Appeal decision. Requests submitted to Us after four (4) months of receipt of the NSA internal Appeal decision will not be considered.

   You are required to sign and return the form included in the NSA internal Appeal denial notice which authorizes release of medical records for review by the IRO. Appeals submitted by Your Provider will not be accepted without this form completed with Your signature.

   The NSA External Appeals request should be submitted in writing to:

   Blue Cross and Blue Shield of Louisiana

   Appeals/Grievances Department

   P.O. Box 98045

   Baton Rouge, LA 70898-9045

   If the Member has questions or needs assistance, the Member may call Our customer service department at the number on the ID card.

   A Member must exhaust all NSA internal Appeal opportunities prior to requesting an NSA External Appeal conducted by an IRO.

We will provide the IRO all pertinent information necessary to conduct the NSA External Appeal. The external review will be completed within forty-five (45) days of Our receipt of the request for an NSA External Appeal. The IRO will notify the Member, his authorized representative, or a Provider authorized to act on the Member's behalf of its decision.

The IRO decision will be considered a final and binding decision on both the Member and Us for purposes of determining coverage under this [Benefit Plan/Contract]. This NSA External Appeal process shall constitute Your sole recourse in disputes concerning whether the Company complied with the surprise billing and cost-sharing protections of the NSA, except to the extent that other remedies are available under state or federal law.

The Member may contact 1-800-985-3059 or visit **www.cms.gov/nosurprises** for more information about Member rights under the NSA.

ARTICLE XXIV. COORDINATION OF BENEFITS

A. Applicability

This section applies when a Member has healthcare coverage under more than one Plan. Plan is defined below.

The Order of Benefit Determination Rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its terms of coverage without concern of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed one hundred percent (100%) of the total Allowable Expense.

B. Definitions *(Applicable only to this Coordination of Benefits Article of this Contract)*

1. Allowable Expense – Healthcare services or expenses, including deductibles, coinsurance or copayments, that are covered in full or in part by any Plan covering a Member. The following are examples of services or expenses that are and are not Allowable Expenses.

   a. A healthcare service or expense or a portion of a service or expense that is not covered by any of the Plans covering a Member is not an Allowable Expense.

   b. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

   c. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

   d. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

   e. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   f. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology

and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all Plans.

g. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, prior Authorization of admissions and preferred provider arrangements.

2. Closed Panel Plan – A Plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

3. Coordination of Benefits or COB – A provision establishing an order in which Plans pay their claims and permitting Secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. The COB provision applies to the part of the Benefit Plan providing healthcare Benefits which may be reduced because of the benefits of other Plans. Any other part of the Benefit Plan providing healthcare Benefits is separate from this plan. This Benefit Plan may apply one COB provision to certain Benefits, such as dental Benefits, coordinating only with similar Benefits, and may apply another COB provision to coordinate other Benefits.

4. Custodial Parent –

   a. the parent awarded custody of a covered child by a court decree; or

   b. in the absence of a court decree, the parent with whom the covered child resides more than one half of the calendar year without regard to any temporary visitation.

5. Order of Benefit Determination Rules – Rules that determine whether this Benefit Plan is a Primary Plan or Secondary Plan when a Member has healthcare coverage under more than one Plan. When this Benefit Plan is Primary, We determine payment for Benefits first before those of any other Plan and without considering any other Plan's benefits. When this Benefit Plan is Secondary, We determine Benefits after those of another Plan and may reduce the Benefits We pay so that all plan Benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

6. Plan – Any of the following that provide benefits or services for medical or dental care or treatment. If separate Plans or contracts are used to provide coordinated coverage for members of a group, the separate Plans or contracts are considered parts of the same Plan and there is no COB among those separate Plans or contracts.

   a. Plan includes:

      (1) group and non-group insurance contracts;

      (2) health maintenance organization (HMO) contracts;

      (3) group or group-type coverage through Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured);

      (4) the medical care components of long-term care contracts, such as skilled nursing care;

      (5) the medical benefits in group or individual automobile no fault and traditional automobile or fault contracts; and

      (6) Medicare or any other governmental benefits, as permitted by law.

b. Plan does not include:

(1) hospital indemnity coverage benefits or other fixed indemnity coverage;

(2) accident only coverage;

(3) specified disease or specified accident coverage;

(4) limited benefit health coverage as defined by state law;

(5) school accident-type coverage except those enumerated in La. R.S. 22:1000(A)(3)(C);

(6) benefits for non-medical components of long-term care contracts;

(7) Medicare supplement policies;

(8) Medicaid plans; or

(9) coverage under other government Plans, unless permitted by law.

Each contract for coverage under (6)(a) or (b), above, is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

7. Primary Plan – A Plan whose benefits for a covered person's healthcare coverage must be determined without taking the existence of any other Plan into consideration.

8. Secondary Plan – A Plan that is not a Primary Plan and determines its benefits after the Primary Plan pays benefits.

C. Coordination of Benefits and Order of Benefit Determinations

1. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows.

a. The Primary Plan pays or provides its benefits according to its terms of coverage and without concern of the benefits under any other Plan.

b. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan will pay or provide benefits as if it were the Primary Plan when a covered person uses a non-panel provider, except for Emergency services or authorized referrals that are paid or provided by the Closed Panel Plan.

c. When multiple contracts providing coordinated coverage are treated as a single Plan under the Louisiana Department of Insurance (LDI) Regulation 32, then this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the Plan, the issuer designated as Primary within the Plan will be responsible for the Plan's compliance with LDI Regulation 32.

d. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination Rules of LDI Regulation 32 decide the order in which Secondary Plans benefits are determined in relation to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan, which, under LDI Regulation 32, has benefits determined before those of that Secondary Plan.

e. Except as provided in (f) below, a Plan that does not contain a Coordination of Benefits provision that is consistent with LDI Regulation 32 is always Primary unless the provisions of both Plans state that the complying Plan is Primary.

f. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

2. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is the Secondary Plan.

3. Order of Benefit Determination

Each Plan determines its order of benefits using the first of the following provisions that apply.

a. Non-Dependent or Dependent Provision

The Plan that covers the person other than as a dependent, for example, as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a dependent; and Primary to the Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed. The Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

b. Dependent Child Covered Under More Than One Plan Provision

Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows.

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This provision applies to plan years commencing after the Plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of subparagraph (3)(b)(1) above will determine the order of benefits;

(c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of subparagraph (3)(b)(1) above will determine the order of benefits; or

(d) If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

(i) The Plan covering the Custodial Parent;

(ii) The Plan covering the spouse of the Custodial Parent;

(iii) The Plan covering the non-Custodial Parent; and then

(iv) The Plan covering the spouse of the non-Custodial Parent.

(3) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraphs (3)(b)(1) or (3)(b)(2) above shall determine the order of benefits as if those individuals were the parents of the child.

(4) For a dependent child covered under the spouse's Plan:

(a) For a dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a dependent under a spouse's Plan, the Longer or Shorter Length of Coverage Provision, below, applies.

(b) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits will be determined by applying the birthday rule above in subparagraph (3)(b)(1) to the child's parent(s) and the dependent's spouse.

c. Active Employee or Retired or Laid-off Employee Provision

The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

d. COBRA or State Continuation Coverage Provision

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this provision, and as a result, the Plans do not agree on the order of benefits, this provision is ignored. This provision does not apply if the Non-Dependent or Dependent Provision, above, can determine the order of benefits.

e. Longer or Shorter Length of Coverage Provision

The Plan that covered the person as an employee, member, policyholder, subscriber or retiree for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

f. Fall-Back Provision

If none of the preceding provisions determines the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, this Benefit Plan will never pay more than We would have paid had We been the Primary Plan.

D. Effects on the Benefits of this Plan

1. When this Benefit Plan is Secondary, We may reduce Benefits so that the total Benefits paid or provided by all Plans during a plan year are not more than one hundred percent (100%) of the total Allowable Expenses. In determining the amount to be paid for any Claim, as the Secondary Plan, We will calculate the Benefits We would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under Our Benefit Plan that is unpaid by the Primary Plan. As the Secondary Plan, We may then reduce Our payment by the amount so that, when combined with the amount paid by the Primary Plan, the total Benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, as the Secondary Plan, We will credit to the Benefit Plan Deductible Amount any amounts We would have credited to the Deductible Amount in the absence of other healthcare coverage. In any event, this Benefit Plan will never pay more than We would have paid had We been the Primary Plan.
2. The difference between the Benefit payments that We would have paid had We been the Primary Plan, and the Benefit payments that We actually paid or provided shall be recorded as a benefit reserve for You or a covered family member and used by Us to pay any Allowable Expenses, not otherwise paid during the plan year. As each Claim is submitted, We will:

   a. determine Our obligation to pay or provide Benefits under the Benefit Plan;

   b. determine whether a benefit reserve has been recorded for You or Your covered family member; and

   c. determine whether there are any unpaid Allowable Expenses during the plan year.

3. If there is a benefit reserve, We will use Your or Your covered family member's benefit reserve to pay up to one hundred percent (100%) of total Allowable Expenses incurred during the plan year. At the end of the plan year, the benefit reserve returns to zero. A new benefit reserve must be created for each new plan year.
4. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB will not apply between that Plan and other Closed Panel Plans.

You may request a copy in either paper form or electronic form of LDI Regulation 32 - Appendix C, which provides an explanation for Secondary Plans on the purpose and use of the benefit reserve and how Secondary Plans calculate claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at **https://www.ldi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32-appendixc.pdf?sfvrsn=24e14b52_0.**

E. Summary

This is a summary of only a few of the provisions of Your Benefit Plan to help You understand Coordination of Benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines Your Benefits.

1. Double Coverage

   It is common for family members to be covered by more than one healthcare Plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When You are covered by more than one healthcare Plan, state law permits Your insurers to follow a procedure called Coordination of Benefits to determine how much each should pay when You have a Claim. The goal is to make sure that the combined payments of all Plans do not add up to more than Your covered healthcare expenses. Coordination of Benefits is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2. Primary or Secondary

   You will be asked to identify all the Plans that cover members of Your family. We need this information to determine whether We are the Primary or Secondary benefit payer. The Primary Plan always pays first when You have a Claim. Any Plan that does not contain Your state's COB rules will always be Primary.

3. When this Benefit Plan is Primary

   If You or a family member are covered under another Plan in addition to this one, We will be Primary when:

   a. The Claim is for Your own healthcare expenses, unless You are covered by Medicare and both You and Your Spouse are retired;

   b. The Claim is for Your Spouse's healthcare expenses, who is covered by Medicare, and You are not both retired;

   c. The Claim is for the healthcare expenses of Your Dependent child who is covered by this Benefit Plan and:

      (1) You are married and Your birthday is earlier in the year than Your Spouse's or You are living with another individual, regardless of whether or not You have ever been married to that individual, and Your birthday is earlier than that other individual's birthday. This is known as the birthday provision;

      (2) You are separated or divorced and You have informed Us of a court decree that makes You responsible for Your Dependent child's healthcare expenses; or

      (3) There is no court decree, but You have custody of Your Dependent child.

4. Other Situations

   a. We will be Primary when any other provisions of state or federal law require Us to be. When We are the Primary Plan, We will pay the Benefits in accordance with the terms of Your Benefit Plan, just as if You had no other healthcare coverage under any other Plan.

   b. We will be Secondary whenever the rules do not require Us to be Primary. When We are the Secondary Plan, We do not pay until after the Primary Plan has paid its benefits. We will then pay part, or all of the Allowable Expenses left unpaid, as explained below. An Allowable Expense is a healthcare service or expense covered by one of the Plans, including Copayments, Coinsurance and Deductible Amounts.

      (1) If there is a difference between the amount the Plans allow, We will base Our payment on the higher amount. However, if the Primary Plan has a contract with the provider, Our combined

payments will not be more than the provider contract calls for. Health maintenance organizations and preferred provider organizations usually have contracts with their providers.

(2) We will determine Our payment by subtracting the amount the Primary Plan paid from the amount We would have paid if We had been Primary. We will use any savings to pay the balance of any unpaid Allowable Expenses covered by either Plan.

(3) If the Primary Plan covers similar kinds of healthcare expenses, but allows expenses that We do not cover, We will pay for those items as long as there is a balance in Your benefit reserve, as explained below.

(4) We will not pay an amount the Primary Plan did not cover because You did not follow its rules and procedures. For example, if the Plan has reduced its benefit because You did not obtain prior Authorization, as required by that Plan, We will not pay the amount of the reduction, because it is not an Allowable Expense.

c. Benefit Reserve

When We are Secondary We often will pay less than We would have paid if We had been Primary. Each time We save by paying less, We will put that savings into a benefit reserve. Each family member covered by this Benefit Plan has a separate benefit reserve. We use the benefit reserve to pay Allowable Expenses that are covered only partially by both Plans. To obtain a reimbursement, You must show Us what the Primary Plan has paid so We can calculate the savings. To make sure You receive the full Benefit or coordination, You should submit all Claims to each of Your Plans. Savings can build up in Your reserve for one plan year. At the end of the plan year any balance is erased. A new benefit reserve begins for each person the next year as soon as there are savings on Claims.

F. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person for the purpose of determining COB. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Benefit Plan must give Us any facts We need to pay the Claim.

G. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Benefit Plan. We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a Benefit paid under this Benefit Plan. To the extent such payments are made, they discharge Us from further liability. The term payment made includes providing Benefits in the form of services, in which case the payment made will be the reasonable cash value of any Benefits provided in the form of services.

H. Right of Recovery

If the amount of the payments that We made is more than We should have paid under this COB section, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;

2. insurance companies; or

3. other organizations.

The amount of the payments made includes the reasonable cash value of any Benefits provided in the form of services.

ARTICLE XXV. HOW TO MAKE POLICY CHANGES AND FILE CLAIMS

Blue Cross and Blue Shield of Louisiana is continuing to update its online access for Members. Members may now be able to perform many of the functions described below, without contacting Our customer service unit. We invite Members to log on to **www.bcbsla.com** for access to these services.

All of the forms mentioned in this section can be obtained from the home office of Blue Cross and Blue Shield of Louisiana.

If You need to submit documentation to Us, You may forward it to Our home office at Blue Cross and Blue Shield of Louisiana at P. O. Box 98029, Baton Rouge, LA 70898-9029, or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If You have any questions about any of the information in this section, You may call Your insurance agent or Our customer service department at the number shown on the ID card.

Changing Family Members on the Member's Policy

The Schedule of Eligibility lets You know when You may add additional family members to the Member's Benefit Plan. The Member should read the Schedule of Eligibility and this section as they contain important information.

A Change of Status Card is required to add newborn children, newborn adopted children, a Spouse, or other Dependents to coverage. We should receive Your completed form in Our home office within thirty (30) days of the child's birth or placement, or Your marriage. A Change of Status Card is also required to remove existing family Members from coverage.

If You do not complete and return a required Change of Status Card to Us within the timeframes set out in the Schedule of Eligibility, it is possible that Your insurance coverage will not be expanded to include the additional family Members. Completing and returning a Change of Status Card is especially important when Your first Dependent becomes eligible for coverage or when You no longer have any eligible Dependents.

How to File Insurance Claims for Benefits

The Company and most Providers have entered into agreements that eliminate the need for a Member to personally file a Claim for Benefits. Preferred or Participating Providers will file Claims for Members either by mail or electronically. In certain situations, the Provider may request the Member to file the Claim. If the Member's Provider does request them to file directly with Us the following information will help the Member in correctly completing the Claim form. If You need to file a paper Claim, send it to the address below.

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

The Member's Blue Cross and Blue Shield ID card shows the way the name of the Subscriber (Member of the University) appears on Our records. (If the Member has Dependent coverage the name(s) are recorded as shown in the enrollment information We received.) The ID card also lists the Member's Contract number (ID #). This number is the identification to the Member's membership records and should be provided to Us each time a Claim is filed.
To assist in promptly handling the Member's Claims, please be sure that:

a. an appropriate Claim form is used
b. the Contract number (ID #) shown on the form is identical to the number on the ID card
c. the patient's date of birth is listed
d. the patient's relationship to the Subscriber is correctly stated
e. all charges are itemized on statement
f. the itemized statement from the Provider contains the Provider's name, address and tax ID number and is attached to the Claim form

g. the date of service (date of admission to a Hospital or other Provider) or date of treatment is correct

h. the Provider includes a diagnosis code and a procedure code for each service/treatment rendered (the diagnosis code pointers must be consistent with the Claim form)
i. the Claim is completed and signed by the Member and the Provider.

Prescription Drug Claims

Most Members with Prescription Drug coverage will not be required to file Claims to obtain Prescription Drug Benefits as this is done automatically for the Members who presents an ID card to a Participating Pharmacist. However, if the Member must file a Claim to access their Prescription Drug Benefit, the Member must use the Prescription Drug Claim Form. Members may obtain the Prescription Drug Claim form by accessing the pharmacy section of Our website, **www.bcbsla.com/pharmacy.** The Prescription Drug Claim Form, or an attachment acceptable to Us, may require the signature of the dispensing pharmacist. The Claim form should then be sent to Blue Cross and Blue Shield of Louisiana's Pharmacy Benefit Manager, whose telephone number is on the ID card.

Benefits will be paid to the Member based on the Allowable Charge for the Prescription Drug.

Other Medical Claims

When the Member receives other medical services (clinics, Provider offices, etc.) the Member should ask if the Provider is a Preferred or Participating Provider. If yes, this Provider will file the Member's Claim with Us. In some situations, the Providers may request payment and ask the Member to file. If this occurs, the Member should be sure the Claim form is complete before forwarding to Blue Cross and Blue Shield of Louisiana.

If the Member is filing the Claim the Claim must contain the itemized charges for each procedure or service. NOTE: Statements, canceled checks, payment receipts and balance forward bills may not be used in place of itemized bills. Itemized bills submitted with Claim forms must include the following:

a. full name of patient
b. date(s) of service
c. description of and procedure code for service
d. diagnosis code
e. charge for service
f. name and address of Provider of service.

Claims for Nursing Services

A receipt must be obtained for nursing services from each nurse indicating the name of the patient and the number of days covered by each receipt. Each receipt must also be signed by the nurse with the initials RN or LPN and registry number. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary may also need to be filed with the receipts for nursing services.

Claims for Durable Medical Equipment (DME)

Charges for rental or purchase of wheelchairs, braces, crutches, etc. must be on the bill of the supplying firm, giving a description of the item rented or purchased, the date, the charge, and the patient's name. A statement from the attending Physician or Allied Health Provider that services were Medically Necessary must also be filed with these bills.

Claims for Mental Health and Substance Use Disorders

For help with filing a Claim for the treatment of Mental Health or substance use disorders, the Member should refer to the ID card or call Our customer service department.

Claims Questions

Members can view information about the processing or payment of a Claim online at **www.bcbsla.com**, Members can also write Us at the following address or call Our customer service department at the number shown on the ID card or

visit any of Our local service offices*. If the Member calls for information about a Claim, We can help the Member better if they have the information at hand, particularly the contract number, patient's name and date of service.

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

Remember, the Member should ALWAYS refer to their contract number in all correspondence and recheck it against the Benefit Plan number on the ID card to be sure it is correct.

Our local service offices are located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE XXVI. GENERAL PROVISIONS – UNIVERSITY/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR UNIVERSITY AND MEMBERS ARTICLE, THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE UNIVERSITY.

A. Due Date for University's Premium Payments

1. Premiums are due and payable in advance, from the University, prior to coverage being rendered. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. This is the premium due date.

2. Premiums are owed by University/policyholder. Premiums may not be paid by third-parties, including but not limited to Hospitals, Pharmacies, Physicians, automobile insurance carriers, or other insurance carriers. The Company will not accept premium payments by third-parties unless required by law to do so. The fact that the Company may have previously accepted a premium from an unrelated third-party does not mean that the Company will accept premiums from these parties in the future.

3. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean we will accept late premiums in the future. You may not rely on the fact that we may have previously accepted a late premium as indication that we will do so in the future.

4. Premiums must be paid in US dollars. Policyholder will be assessed a twenty-five dollar ($25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, the Company may at its sole discretion refuse to reinstate coverage.

B. Change in Premium Amount

1. Premiums are guaranteed for the Policy Year. However, We reserve the right to change premiums more often due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Contract. This risk includes, but is not limited to, the addition of a newly covered person. Additionally, We reserve the right to change the premium if You request a change in Benefits from that which was in force at the time of the last rate determination.

2. We will give University forty-five (45) days written notice of any change in premium rates. We will send notice to the University's latest address shown in Our records. Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.

C. University to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, the Company will pay the University/policyholder the total rebate applicable to the Policy, and University, on behalf of the Company, will distribute from the rebate a pro-rata share of the rebate to each Subscriber based upon their contribution to the premium rebated. University shall assure appropriate notification to federal and state tax agencies and that each payment to Subscribers will be accompanied by appropriate federal and state documentation, e.g., Form 1099. University shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to the Company upon request. Such records shall include:

1. the amount of the premium paid by each Subscriber;
2. the amount of the premium paid by the University;
3. the amount of the rebate provided to each Subscriber;
4. the amount of the rebate retained by the University; and
5. the amount of any unclaimed rebate and how and when it will be or was distributed.

University will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Subscriber's state of domicile. University will indemnify the Company in the

event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the University's failure to carry out its obligations under this Section of the Group Health Benefit Plan.

D. University's Right to Cancel the Policy

1. This policy is guaranteed renewable at the option of the University. University indicates its desire to continue coverage by its timely payment of each premium as it becomes due.

2. University may cancel this policy for any reason.

3. To cancel the policy, University must give the Company WRITTEN NOTICE of its intent to cancel. UNIVERSITY MAY NOT VERBALLY CANCEL THIS COVERAGE. UNIVERSITY'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO THE COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE INSURANCE POLICY. If University's written notice to the Company of its intent to cancel is not accompanied by the surrendered policy, University's cancellation notice to the Company shall be deemed to include University's declaration that the University made a good faith attempt to locate its policy and the policy is not returned because it has been lost or destroyed.

E. The Company's Right to Terminate the Plan for Nonpayment of Premium

1. Premiums are to be prepaid before coverage is rendered. The University is considered delinquent if premiums are not paid on the due date.

2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the Benefit Plan. If We do not receive the premium during the grace period, We will mail a delinquency/termination notice to the University's address of record. We may automatically terminate the plan without further notice to the University if we do not receive the University's premium at Our home office within thirty (30) days of the due date (during the grace period). If We terminate this Benefit Plan for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

3. The University/policyholder agrees to pay reasonable costs and fees to the Company, including reasonable attorney's fees, for the Company's attempt to collect any amounts owed under this Benefit Plan, including, but not limited to, unpaid premium.

F. The Company's Right to Terminate the Policy for Reasons Other Than Nonpayment of Premium

1. The Company may terminate this Benefit Plan if any one of the following occurs:

   a. The University commits fraud or makes an intentional misrepresentation.

   b. The University fails to comply with a material plan provision.

   c. In the case of Network plans, there is no longer any enrollee under the group Benefit Plan that lives, resides, or works in the Service Area of the Company or in the area for which the Company is Authorized to do business.

   d. The Group's coverage is provided through a bona fide association and the employer's membership in the association ends.

   e. The Company ceases to offer this product or coverage in the market.

2. If the Company terminates this coverage because of a, b, c, or d, We will give University written notice at least sixty (60) days in advance. The Company will give notice by certified mail and shall include the reason for termination. Notice of termination because of e will be sent to the University by regular mail

ninety (90) days in advance of termination.

G. Out-of-Area Services

Please refer to the Out-of-Area Services section in the General Provisions – Group / Policyholder and Members Article of this Benefit Plan for further explanation of these Inter-Plan Arrangements and the BlueCard® Program.

Blue Cross and Blue Shield of Louisiana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross and Blue Shield Association (“Association”). Whenever Members access Covered Services outside the geographic area We serve, the Claim for those services may be processed through one of these Inter-Plan Arrangements, and the other Blue Cross and/or Blue Shield Licensee (“Host Blue”) will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard® Program are described generally below.

1. BlueCard® Program Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's billed charges for Covered Services or the negotiated price made available to Us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue’s healthcare Provider contracts. The negotiated price made available to Us by the Host Blue may be represented by one of the following:

a. An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases, or

b. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

c. An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for Claims already paid to Providers or anticipated to be paid to or refunds received or anticipated to be received from Providers). However, the BlueCard® Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims. The method of Claims payment by Host Blues is taken into account by Us in determining Group’s/policyholder’s premiums.

2. Special Cases: Value-Based Programs

We have included a factor for bulk distributions from Host Blues in Group’s/policyholder’s premium for Value-Based Programs when applicable under this Benefit Plan.

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

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable We will include any such surcharge, tax or other fee as part of the Claim charge that will be used to determine any Member liability, and will use them in determining Group's/policyholder's premium.

4. Non-Participating Providers Outside Our Service Area

For an explanation on how liability calculations are made for the Claims of Non-Participating Providers outside Our service area, please refer to the Out-of Area Services section in the General Provisions – Group/Policyholder and Members Article of this Benefit Plan.

H. Proxy Votes

Election of the Board of Directors of the Plan and certain significant corporate transactions are determined by majority vote of its policyholders, unless a different vote is required by law or the Plan's Articles of Incorporation or Bylaws. A policyholder designates, by means of the application for coverage, the members of the Board of Directors of the Plan as his proxy to vote on these important matters. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder. This proxy may be revoked by the policyholder by giving written notice of the revocation. This revocation may be in any form of writing either revoking the proxy or designating a different proxy and must be sent to the Plan at:

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

In lieu of giving his proxy on the application for coverage, the policyholder may designate any other policyholder as his proxy by any form of writing which includes the policyholder's name and Benefit Plan number, sent to the Plan as indicated above. Notice of meetings to the proxy constitutes notice to the policyholders giving their proxies. Further, notice is hereby given that the annual meeting of the Plan is held on in the month of February with notice of the date of that meeting being given as required by law and the articles and bylaws of the Louisiana Health and Service Indemnity Company. However, additional notice of meetings will be sent to any policyholder or his proxy upon his written request for such notice directed to Our secretary.

I. United States Economic Sanctions Laws Compliance

The University hereby agrees to comply fully with all applicable economic sanctions and export control laws and regulations, including those regulations maintained by the United States Treasury Department's Office of Foreign Assets Control (OFAC). The University understands that Blue Cross and Blue Shield of Louisiana does not authorize extending coverage to any person to whom the provision of such coverage would be receiving insurance coverage under this or other Blue Cross and Blue Shield of Louisiana Policies, including Subscribers and their covered Dependents, against all relevant United States Government lists of persons subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person. The University agrees that its acceptance of coverage constitutes a representation to Blue Cross and Blue Shield of Louisiana that all applicable laws and regulations have been complied with and that coverage is not being provided to any denied person.

Any extension of coverage in breach of the foregoing shall constitute cause for immediate termination of this Benefit Plan, and denial of Benefits for any Claims made under that coverage, and shall entitle Blue Cross and Blue Shield of Louisiana to indemnification from the University for any cost, loss, damage, liability, or expense incurred by Blue Cross and Blue Shield of Louisiana as a result thereof. This provision shall survive termination or cancellation of this Benefit Plan.

J. Health Insurance Portability and Accountability Act (Privacy and Security)

1. For purposes of this provision, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

   a. "Group Health Plan" as defined at 45 CFR Part 160, Sec. 160.103.

   b. "Protected Health Information" (PHI) as defined at 45 CFR Part 164, Sec. 164.501.

   c. "Summary Health Information" as defined at 45 CFR Part 164, Sec. 164.504(a).

2. Disclosing Information to the University

   a. Sharing Summary Health Information With the University:

      The Company may disclose Summary Health Information to the University if the University requests Summary Health Information for purposes of obtaining premium bids from health insurers, HMOs or other third-party payers under the Group Health Plan; or modifying, amending or terminating the Group Health Plan.

   b. Sharing PHI with the University:

      The Company may disclose PHI to the University to enable the University to carry out plan administration functions only upon receipt of a certification from the University that:

      (1) its plan documents include all of the requirements set forth in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);

      (2) it has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520 (B)(1)(iii)(C); and that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other Benefits or plan of the University.

   c. The University hereby agrees to abide by the Company's acknowledgement and Authorization policies with regards to the exchange of PHI in an electronic format. For example, if the Company provides data to the University on a compact disc, the Company may require acknowledgement that the University and the name of the University representative, which received the data.

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)