



STUDENT GROUP HEALTH
INSURANCE BENEFIT PLAN
NEEDLESTICK COVERAGE

THIS IS A LIMITED BENEFIT CONTRACT - READ CAREFULLY



Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

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**STUDENT GROUP HEALTH INSURANCE
LIMITED BENEFIT PLAN
NEEDLESTICK COVERAGE ONLY**

NOTICES

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

When a Subscriber receives Covered Services from a Non-Participating Hospital, the Benefits that the Company will pay under this Benefit Plan will be reduced by thirty percent (30%).

A handwritten signature in black ink, reading 'B R Camerlinck'.

Bryan R. Camerlinck
President and Chief Executive Officer

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ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

THIS IS A LIMITED BENEFIT PLAN PROVIDING COVERAGE FOR NEEDLESTICKS ONLY. PLEASE READ CAREFULLY.

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

As of the amended Effective Date shown on the Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers of the University. This amended Effective Date replaces any others previously issued to the University as of the original Effective Date or amended Effective 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.

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. 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.

A. Facts About This Student Group Health Insurance Limited Needlestick Benefit Plan

This is a limited benefit blanket group health insurance plan written by Blue Cross and Blue Shield of Louisiana and issued to the University. It is a student health insurance policy intended to cover the University's Eligible Students as defined in the Benefit Plan.

This Plan provides student coverage for needlesticks only. It is not a comprehensive medical plan. In order to maximize Your student health service benefits, You may wish to 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 Preferred Care PPO Network Provider because Your cost will generally be lower than seeing a Non-Network Provider.

B. Our Provider Network

Subscribers have the right to use Providers of their choice. The Subscriber's choice of Provider will impact whether the Subscriber must pay anything toward Covered Services. When You receive Covered Services from Your student health center or a Provider in Our Preferred Care PPO Network, You will owe nothing for care covered under this Benefit Plan.

Our Preferred Care PPO 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 Preferred Care PPO Provider Network and render services to Subscribers. We call these Providers PPO Providers, Preferred Providers, or Network Providers.

Subscribers should know that care received from a Non-Network Physician, facility or other healthcare professional means a cost to the Subscriber. We pay a Non-Network Provider the amount a Network Provider would accept for the same service. It is the Subscriber's responsibility to pay the remainder of a Non-Network Provider's bill up to the billed charge. To obtain the highest level of Benefits available, the Subscriber should always verify that a Provider is a current Blue Cross and Blue Shield of Louisiana Preferred Care PPO Provider before the service is rendered. Visit Our website at www.lablue.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. Subscribers should always verify the Network status of a Provider before obtaining services.

C. Health Management and Wellness Tools And Resources

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

D. 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@lblue.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.lblue.com and click on Need Help? to access our Help Center which includes Our customer service contact information.

ARTICLE II. DEFINITIONS

The inclusion of any definition in this Article does not denote that any particular benefit, condition, diagnosis, procedure, service, or treatment is covered under this Benefit Plan. Please review the Benefit Plan in its entirety to determine Your coverage.

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 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 Care PPO 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 Providers services covered under the terms of this Benefit Plan.
- 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.

Appeal – A written request from the Subscriber or the Subscriber's authorized representative to change a decision made by the Company about Your Benefits.

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 Period – A calendar year, January 1 through December 31. For new Subscribers, the Benefit Period begins on the Effective Date and ends on December 31 of the same year.

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 to Benefits.

Benefit Plan Date – The date upon which We issued this Benefit Plan to the University, also known as the University's original effective date, as shown on the Schedule of Benefits.

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.

Claim – Written or electronic proof, in a form acceptable to Us, of charges for Covered Services that have been incurred by the Subscriber during the time-period the Subscriber 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.

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.

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

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

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.

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.

Hospital – An institution that is licensed by the appropriate state agency as a general medical surgical Hospital.

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

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.

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 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 PPO Provider Network or another PPO Network. This Provider may also be referred to as a Preferred Provider or In-Network Provider. Participating Providers are Network Providers for purposes of this Limited Benefit Needlestick plan.

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

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

Outpatient – A Subscriber who receives services or supplies while not a Hospital inpatient.

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

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 Subscribers 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 that has signed a contract with Us or another Blue Cross and Blue Shield plan to participate in Our Preferred Care 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 PPO Network, or has a signed contract with another Blue Cross and Blue Shield plan to participate in its Provider Networks. For purposes of this Limited Benefit Needlestick plan, these are considered Network Providers.
- C. Non-Participating Provider – A Provider that has not signed a contract with Us, HMO Louisiana, Inc., or another Blue Cross and Blue Shield plan. These are Non-Network Providers.

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.

Subscriber – An Eligible Student who is properly enrolled under the Benefit Plan. The Subscriber is the person on whose behalf the Benefit Plan is issued to the University.

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.

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.

A. Eligibility

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.

B. Application for Coverage

1. Every Eligible Student may enroll for coverage under this Benefit Plan.
2. Eligible Students have ninety (90) days to enroll in this Benefit Plan from the following effective dates:
 - a. January 1st;
 - b. May 1st; or
 - c. July 1st.
3. The University will submit all enrollment information to Us as a prerequisite to coverage under this Benefit Plan.
4. 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 affect coverage unless and until an 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 class of coverage is available:

Subscriber only – Subscriber only coverage means coverage for the Eligible Student only.

A. Enrollment and Effective Date

1. Initial Enrollment Period

Eligible Students may enroll for coverage under this plan 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. When enrollment has been accepted and any premiums for coverage have been paid, coverage will begin on the applicable Effective Date.

If a person is an Eligible Student on the University's Benefit Plan Date and enrolls for coverage 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 for coverage. The Open Enrollment Period shall be provided on an annual, semi-annual and summer-only basis.

If a person becomes an Eligible Student after the University's Benefit Plan Date, and enrolls for coverage 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.

3. Annual and Semi-Annual Effective Date

The University designates an Annual Coverage Period Effective Date, Fall Semi-Annual Effective Date, Spring Semi-Annual Effective Date or Summer Coverage Period Effective Date for Subscribers newly enrolled under the plan. If You enroll for coverage during the Initial Enrollment Period, Your coverage begins on either the Annual Coverage Period 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 Coverage Period Effective Date specified by the University. Effective Dates are shown on the Schedule of Benefits.

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: Benefits for Covered Services received from Providers contracted in the Preferred Care PPO Network or another Blue plan's PPO Network.
2. Non-Network Benefits: Benefits for Covered Services received from Providers not contracted in the Preferred Care PPO Network or another Blue plan's PPO Network.

B. Benefit Payment:

We will pay 100% of the Allowable Charge for the Covered Services rendered to a Subscriber for Benefits provided under this Benefit Plan. Our actual payment to a Provider or payment to the Subscriber satisfies Our obligation to provide Benefits under this Benefit Plan. Subscribers that receive Covered Services from Non-Network Providers may be billed the difference between the Allowable Charge We pay and the Provider's billed charge. If the Non-Network (Non-Participating) Provider is a Hospital, Our payment of the Allowable Charge will be reduced by thirty percent (30%).

ARTICLE V. NEEDLESTICK BENEFIT

The following Benefit is the sole Benefit available on this limited benefit plan.

Coverage is provided for Subscribers for testing and prophylactic treatment of blood borne diseases following at risk contact with blood or other bodily fluids from human or animal sources. The contact may include, but is not limited to, needlesticks. 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 Hospital admission, additional or follow-up testing or treatment not specific to needlesticks, antiviral or antibiotic treatments or pharmacy benefits outside of those specifically listed as covered on the Schedule of Benefits.

ARTICLE VI. LIMITATIONS AND EXCLUSIONS

- A. ANY LIMITATION OR EXCLUSION LISTED IN THIS BENEFIT PLAN MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS OR BY AMENDMENT.**
- B. Benefits for conditions, services, surgery, supplies and treatment for services that are not covered under this Limited Benefit Plan are excluded.
- C. Unless otherwise shown as covered in the Benefit Plan or on the Schedule of Benefits, the following are excluded:
1. Any charges exceeding the Allowable Charge.
 2. Hospital admissions or charges.
 3. Prescription drugs or pharmacy charges, except as provided herein.
 5. Benefits are excluded for services, supplies, treatment, or expenses:
 - a. other than those specifically listed as covered by this Benefit Plan or for which a Subscriber has no obligation to pay, or for which no charge would be made if a Subscriber did not have this 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 Subscriber's Effective Date or after the Subscriber's coverage terminates;
 - c. which are performed by or upon the direction of a Provider, Physician or Allied Health Professional acting outside the scope of his or her license;
 - d. which are Investigational in nature;
 - e. ordered, prescribed, or rendered by a Provider who is related to a Subscriber by blood, marriage or adoption, or who regularly resides in a Subscriber's household;
 - f. for treatment of any Subscriber detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention; and
 - g. for recreational therapy, including, but not limited to, providing treatment, services and recreation activities using a variety of techniques including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings.

ARTICLE VII. GENERAL PROVISIONS – UNIVERSITY/POLICYHOLDER AND SUBSCRIBERS

THE FOLLOWING GENERAL PROVISIONS ARE APPLICABLE TO THE UNIVERSITY/POLICYHOLDER, AND ALL SUBSCRIBERS. 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.

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. 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 Subscriber's care or treatment.
3. The Company has full discretionary authority to determine eligibility for Benefits and/or to construe the terms of this Benefit Plan. Subscribers that disagree with the Company's determination may pursue any applicable procedures available under the terms of this Benefit Plan and the law.
4. 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@lblue.com

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Blue Cross 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. Changes will be effective upon renewal of the Benefit Plan and will be preceded by 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 a 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 the University's Subscribers. At the direction of the University, We will either deliver all materials to the University for the 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 the 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 Subscribers 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 Subscriber's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

F. Notice of Subscriber Eligibility - University's Personnel Data

1. The University is solely responsible for furnishing the information that We require for purposes of enrolling Subscribers of the University under this Benefit Plan, processing terminations, and effecting changes in 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 and billing department of a Subscriber'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 Subscriber 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 the University or any Subscriber, if payment was made to the Company due to the University's failure to timely notify the Company of a Subscriber'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 Subscriber's coverage, the University will be deemed to be making a representation that the Subscriber has not 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 Subscriber 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 as a result 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 may, at its sole option, hold the University responsible for all premium payments for the Subscribers 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 Your Coverage

1. A Subscriber's coverage may be terminated for fraud at any time. A Subscriber's coverage may be terminated within three (3) years of the Subscriber's Effective Date, if material misrepresentation was made in connection with enrollment for coverage.
2. A Subscriber's coverage terminates automatically, and without notice at the end of the billing cycle in which the Subscriber ceases to be eligible. Cancellation will be effective at midnight on the last day of the billing cycle.
3. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Subscriber for Covered Services rendered after the date of termination of a Subscriber's coverage.

H. Filing Claims

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.

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 Subscriber or the Provider furnish certain information relating to the Subscriber'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. Subscriber/Provider Relationship

1. The choice of a Provider is solely the Subscribers choice.
2. We and all Network Providers are to each other independent contractors, and will not be considered 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 Subscriber 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 Subscriber while receiving care from any Provider or in any Provider's facilities. We have no responsibility for a Provider's failure or refusal to render Covered Services to the Subscriber.
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.

L. 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 pre-empted by federal law. 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 provision is 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.

M. 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 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 Subscriber at the 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 Subscriber may, by written notice, indicate a new address for giving notice.

N. 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 Subscriber 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 Subscriber or the Provider.

O. 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 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.

P. 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.

Q. Out-of-Area Services

Blue Cross and Blue Shield of Louisiana has a variety of relationships with other Blue Cross 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 Our geographic area, 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: either Participating or Non-Participating Providers. Most Participating Providers contract with the local Blue Cross or Blue Shield Licensee in that geographic area (Host Blue). Non-Participating Providers do not 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, except for pharmacy 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 in the geographic area that a Host Blue serves, We will do what We agreed to do in the plan. But, the Host Blue must contract with and generally handle 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 Provider or Provider group that may include types of settlements, incentive payments, and 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 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. Those adjustments will not affect the price We used for Your Claim because We will not be apply them after a Claim has already been paid.

2. Special Case: Value-Based Programs

a. BlueCard® Program

Under a Value-Based Program, if You receive Covered Services in a Host Blue's service area, You will not have to pay any of the Provider Incentives, risk-sharing, 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 it applies, 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 You go outside of Our Service Area by Non-Participating Providers for Covered Services, We will normally base on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements that state law requires. In these situations, You may be responsible for the difference between the amount that the Non-Participating Provider bills and how much We pay for the Covered Services as stated in this paragraph.

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 have to pay the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as stated in Your Plan.

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 (BlueCard® service area), You may be able to take advantage of the Blue Cross Blue Shield Global® Core

for Covered Services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program in certain ways. For instance, although the Blue Cross Blue Shield Global® Core helps You access a network of Outpatient and professional Providers, Host Blue does not serve the network. When You go to Providers outside the BlueCard® service area, You will typically have to pay the Providers and submit the Claims Yourself.

For medical assistance services (including finding a doctor) 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.

a. 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.

b. 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 healthcare 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 Benefit Plan 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.

c. 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 be reimbursed. You should complete a Blue Cross Blue Shield Global® Core Claim 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:
1-804-673-1177

R. 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 Subscribers and/or policyholders to participate in quality programs;
2. Ensuring Subscribers and/or policyholders are better able to afford Benefits packages;
3. Reducing and alleviating social determinants of health;
4. Reducing transition costs for Subscribers and/or policyholders who have changed insurers or have ended self-insured coverage and purchased fully insured coverage;
5. Rewarding Subscribers and/or policyholders for choosing lower cost, quality healthcare Providers;
6. Rewarding Subscribers and/or policyholders for selecting lower cost, quality healthcare goods and products;
7. Rewarding Subscribers 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 Subscribers and/or policyholders, when such costs are related to effectuating and/or maintaining coverage.

ARTICLE VIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

We want to know when a Subscriber is dissatisfied about the care or services received from Blue Cross and Blue Shield of Louisiana or one of Our Providers. If a Subscriber wants to register a Complaint or file a formal written Grievance about Us or a Provider, please refer to the procedures below.

We consider an Appeal as the Subscriber's request to change a decision made by the Company about Your Benefits. Your Appeal rights are outlined below, after the Complaint and Grievance procedures

A. Complaint and Grievance 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 Subscriber.

1. To Register a Complaint

A Complaint is an oral expression of dissatisfaction with Us or with Provider services. Subscribers may call customer service to register a Complaint. We will attempt to resolve a Subscriber's Complaint at the time of their call.

Customer Service: call 1-800-599-2583 or 1-225-291-5370

2. To File a Formal Grievance

A Grievance is a written expression of dissatisfaction with Us or with Provider services. If the Subscriber 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 questions or assistance with writing the Grievance, the Subscriber may call Our customer service department.

Send written Grievances to:

Blue Cross and Blue Shield of Louisiana
Appeals/Grievances Department
P. O. Box 98045
Baton Rouge, LA 70898-9045

A response will be mailed to the Subscriber within thirty (30) business days of receipt of the Subscriber's written Grievance.

B. Appeal Process

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

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

The Subscriber 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.

We will provide reasonable access to and copies of all documents, records, and other information relevant to the Appeal.

1. First Level Appeals

If a Subscriber is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days after We denied Benefits. Requests submitted to Us after one hundred eighty (180) days will not be considered.

We will investigate the Subscriber's concerns. If the Appeal is overturned, We will reprocess the Subscriber's Claim, if any. If the Appeal is upheld, We will inform the Subscriber of the right to begin the second level Appeal process.

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

2. Second Level Appeals

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

An Appeals committee of persons not involved in previous decisions regarding the first level Appeals will review the second level Appeals.

The committee's decision will be mailed to the Subscriber, the Subscriber's authorized representative, or a Provider authorized to act on the Subscriber's behalf, within five (5) days of the committee meeting. The committee's decision is final and binding.

Submit written requests to Appeal to:

Blue Cross and Blue Shield of Louisiana
Appeals/Grievances Department
P. O. Box 98045
Baton Rouge, LA 70898-9045

ARTICLE IX. HOW TO MAKE PLAN CHANGES AND FILE CLAIMS

Blue Cross and Blue Shield of Louisiana is continuing to update its online access for Subscribers. Subscribers may now be able to perform many of the functions described below, without contacting Our customer service unit. We invite Subscribers to log on to www.lablue.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.

A. How to File Insurance Claims for Benefits

The Company and most Providers have entered into agreements that eliminate the need for a Subscriber to personally file a Claim for Benefits. Network or Participating Providers will file Claims for Subscribers either by mail or electronically. In certain situations, the Provider may request the Subscriber to file the Claim. If the Subscriber's Provider does request them to file directly with Us the following information will help the Subscriber in correctly completing the Claim form. If You need to file a paper Claim, send it to:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 98029-9029

The ID card shows the way the name of the Subscriber appears on Our records. The ID card also lists the Subscriber's contract number (ID #). This number is the identification to the Subscriber's membership records and should be provided to Us each time a Claim is filed.

To assist in promptly handling the Subscriber'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 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); and
- i. the Claim is completed and signed by the Subscriber and the Provider.

B. Claim's Questions

Subscribers can view information about the processing or payment of a Claim online at www.lablue.com, the Subscribers 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 Subscriber calls for information about a Claim, We can

help the Subscriber better if You have the information at hand--particularly the contract number, patient's name and date of service.

Blue Cross and Blue Shield of Louisiana
Post Office Box 98029
Baton Rouge, LA 70898-9029

* Our local service offices are located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Houma, Monroe and Shreveport.

ARTICLE X. GENERAL PROVISIONS – UNIVERSITY/POLICYHOLDER ONLY

IN ADDITION TO THE GENERAL PROVISIONS FOR UNIVERSITY AND SUBSCRIBERS (SHOWN ABOVE), THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE UNIVERSITY.

A. Termination of Coverage

1. Subject to the following circumstances, We shall renew or continue coverage at the option of the University. We may non-renew or discontinue health insurance coverage under this Benefit Plan only if any one of the following occurs:
 - a. Fraud or intentional misrepresentations.
 - b. Failure by the University to comply with a material plan provision including but not limited to provisions relating to eligibility, group contributions, or group participation rules.
 - c. In the case of Network plans, there is no longer any enrollee under the plan who lives, resides, or works in Our service area or in the area for which We are authorized to do business.
 - d. The Company ceases to offer this product or coverage in the market.
 - e. Nonpayment of premiums.
2. If We terminate this coverage because of a, b, or c, We will give written notice to the University at least sixty (60) days in advance, including the reason for termination. This notice shall be by certified mail and shall include the reason for termination. Notice of termination because of d. will be made to the University by regular mail ninety (90) days in advance of termination. Notice or termination for e. will be given in accordance with the below provisions.
3. The Company reserves the right to terminate the coverage when participation is less than two (2) Subscribers. A sixty (60) day written notification will be provided to the University prior to termination.

B. Payment of Premium and Change in Premium

1. Premiums are due and payable in advance, beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. The University is considered delinquent if premiums are not paid as of the due date.
2. Premiums are owed by the 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. The Company offers a grace period of thirty (30) days from the date the premium is due. If the premium is received during the grace period, coverage remains in effect pursuant to the provisions of the Benefit Plan. If the premium is not received timely, We will mail a notice to the University's address of record at least fifteen (15) days prior to terminating the Benefit Plan for non-payment of premium. The Benefit Plan may be automatically terminated without further notice to the University if the University does not make payment to Our home office within thirty (30) days of the due date (during the grace period). Any termination of this Benefit Plan will be effective at midnight of the last day for which premiums have been paid. The Company will not be liable for any Benefits for services rendered following last date through which premiums have been paid.
4. If a premium is not paid when due, We or an agent authorized by Us may agree to accept a late premium. We are not required to accept late premiums. The fact that We may have previously accepted a late premium does not mean We will accept late premiums in the future.

5. Premiums must be paid in US dollars. The policyholder will be assessed twenty-five dollars (\$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.
6. Premiums for this Benefit Plan may increase after the University's first twelve (12) months of coverage and every six (6) months thereafter, except when premiums may increase more frequently as described in the following paragraph. Except as provided in the following paragraph, We will give forty-five (45) days written notice to the University at the last address shown in Our records regarding any change in rates. Such increase in premiums will become effective on the date specified in the notice and continued payment of premium will constitute acceptance of the change.
7. We reserve the right to increase the premiums more often than stated above due to the University's addition of a newly covered person or entity not previously considered in the rate determination process at any time during the life of the Benefit Plan. Additionally, We reserve the right to increase the premium amount because of:
 - a. any change in age or geographic location of any individual insured or policyholder;
 - b. a change in the extent or nature of the risk of the University; or
 - c. any change in the plan Benefit level from that which was in force at the time of the last rate determination. Such increase of premium will become effective on the next billing date following the effective date of the change. Continued payment of premium will constitute acceptance of the change.
8. The University/policyholder agrees to pay reasonable costs and fees to the Company, including reasonable attorney fees, for the Company's attempt to collect any amounts owed under this Benefit Plan, including, but not limited to, unpaid premium.

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 (including but not limited to Employees, retirees, and elected officials as covered on the University's Benefit Plan) 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. Out-of-Area Services

Please refer to the Out-of-Area Services section in the General Provisions – University / Policyholder and Subscribers 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 Subscribers 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 Subscriber 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 Subscriber 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 the University's/policyholder's premiums.

2. Special Cases: Value-Based Programs

We have included a factor for bulk distributions from Host Blues in the University'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 Subscriber liability, and will use them in determining University'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 – University/Policyholder and Subscribers Article of this Benefit Plan.

E. 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 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 Us at:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, Louisiana 70898-9029.

In lieu of giving proxy on the Application for Coverage, the policyholder may designate any other policyholder as the policyholder's proxy by any form of writing which includes the policyholder's name and contract 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 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 proxy upon written request for such notice directed to Our secretary.

F. 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 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.

G. 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, or modifying, amending or terminating the 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 concerning 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 University representative 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, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email **MeaningfulAccessLanguageTranslation@lablue.com**. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries 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 Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.**

Section 1557 Coordinator
In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
Fax: (225) 298-7240
Email: Section1557Coordinator@lablue.com

- 2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to www.lablue.com/checkmyplan.**

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ມີການຫຼຸ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں۔ ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583۔ سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کمشنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)

