STUDENT GROUP HEALTH INSURANCE BENEFIT PLAN

NEEDLESTICK COVERAGE

THIS IS A LIMITED BENEFIT CONTRACT READ CAREFULLY

Louisiana

40XX1439 R07/19

STUDENT GROUP HEALTH INSURANCE
LIMITED BENEFIT PLAN
NEEDLE STICK COVERAGE ONLY
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I. Steven Udvarhelyi, M.D.
President and Chief Executive Officer

ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

THIS IS A LIMITED BENEFIT POLICY PROVIDING COVERAGE FOR NEEDLE STICKS ONLY. PLEASE READ CAREFULLY.

Blue Cross and Blue Shield of Louisiana issues this Student Group Health Insurance Limited Benefit Plan to the University shown in 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 Benefit Plan Date shown in the University's Schedule of Benefits, We agree to provide the Benefits specified herein for Subscribers of the University. This Benefit Plan replaces any others previously issued to the University 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.

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.

FACTS ABOUT THIS STUDENT GROUP HEALTH INSURANCE LIMITED NEEDLE STICK BENEFIT PLAN

This Benefit Plan 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 University's Eligible Students as defined in the Benefit Plan.

This Plan provides student coverage for Needle Sticks 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 (PCare) PPO Network Provider because Your cost will generally be lower than seeing a Non-Network Provider.

OUR PROVIDER NETWORK

This is a network policy. 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 PPO Network, You will owe nothing for care covered under this policy.

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."

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 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. Members may review a current paper Provider directory, check on-line at **www.bcbsla.com**, or contact Our Customer Service Department at the number listed on their identification (ID) card.

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

NOTICE: 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.

NOTE: 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%).

ASSIGNMENT

1. The Subscriber's rights and Benefits payable under this Benefit Plan are personal to the Subscriber and may not be assigned in whole or in part by the Subscriber. We will recognize assignments of Benefits to both Hospitals and Providers 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 Subscriber may be liable for the cost of medical care, treatment, or services.

2. We reserve the right to pay Network Providers directly instead of paying the Subscriber.

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.

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.

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 "Contact Us".

ARTICLE II. DEFINITIONS

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, in whole or in part, based on:

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

B. the Subscriber's eligibility to participate in the Benefit Plan;

C. any prospective or retrospective review determination; or

D. a Rescission of 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 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.

Appeal - A written request from the Subscriber or his authorized representative to change an Adverse Benefit Determination made by the Company.

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 - A Claim is 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.

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

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.

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

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. Decision not to Authorize an Admission, availability of care, continued Hospital stay, or healthcare service for a Member currently in the emergency room, under observation, or receiving Inpatient care.

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 in the Benefit Plan if We receive the completed enrollment form and any required premium within thirty (30) days of the Effective Date.

Inpatient - A Subscriber 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 Subscriber as an Outpatient, the Subscriber does not meet the criteria for an Inpatient.

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.

Medically Necessary (or “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.

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 Provider Network or another PPO Network. This Provider may also be referred to as a Preferred Provider or In-Network Provider.

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.

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

Outpatient - A Subscriber who receives services or supplies while not an 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 who has entered into 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 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. For purposes of this Limited Benefit Needle Stick policy, these are considered 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.

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.

Rescission of Coverage – Cancellation or discontinuance of coverage that has retroactive effect.

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, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS.

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. 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 affect 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 class of coverage is available: Subscriber Only. Subscriber Only coverage means coverage for the Eligible Student only.

D. Enrollment and Effective Date

1. Initial Enrollment Period

   Eligible Students 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. 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 for self 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 Effective Date," "Fall Semi-Annual Effective Date," "Spring Semi-Annual Effective Date" or "Summer 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 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.

ARTICLE IV. BENEFITS

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

A. Benefit Categories:

1. Network Benefits: Benefits for Covered Services received from Network Providers (Providers contracted in the Preferred Care Network or another Blue Plan's network).

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

B. Benefit Payment:

We will pay 100% of the Allowable Charge for the Covered Services rendered to a Subscriber for Benefits provided under this policy. 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. NEEDLE STICK BENEFIT

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

Coverage is provided for Eligible Students 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, 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.

ARTICLE VI. LIMITATIONS AND EXCLUSIONS

A. Services, supplies and treatment for services that are not covered under this Limited Benefit Plan and complications from services, supplies and treatment for services that are not covered under this Limited Benefit Plan are excluded.

B. Any of the limitations and exclusions listed in this Benefit Plan may be deleted or revised as shown in the Schedule of Benefits. Unless otherwise shown as covered in the Schedule of Benefits, the following are not covered, **REGARDLESS OF CLAIM OF MEDICAL NECESSITY:**

1. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. 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. Inpatient Admissions or charges.

4. Prescription drugs or pharmacy charges, except as provided herein.

5. Services, Surgery, 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 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 Subscriber's Effective Date or after 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 license;

   d. which are Investigational in nature, except as specifically provided in this Benefit Plan. Investigational determinations are made in accordance with Our policies and procedures for such determinations which are on file with the Louisiana Department of Insurance;

   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 Member detained in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.

ARTICLE VII. CONTINUATION OF COVERAGE

There are no Continuation of Coverage Benefits available under this limited Benefit Plan.

ARTICLE VIII. COORDINATION OF BENEFITS

This policy does not coordinate with any other policy. It pays for Covered Benefits independently of any other coverage the Subscriber may have.

ARTICLE IX. 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 University will indemnify and hold Us harmless in the event we incur any liability as a result of the University's failure to do so.

3. We 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.

4. We have 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. We 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 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.

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date You become aware of the alleged discriminatory action.

- 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.

- 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.

- The Section 1557 Coordinator will issue a written decision on the grievance no later than 30 days after it is received.

- You may appeal the decision of the Section 1557 Coordinator by writing to the Section 1557 Grievance Administrator within 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 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

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 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 Contract and 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 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 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 family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate 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 Company to effect changes.

3. The University must notify Our Membership & 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 or any of the Member's Dependents is terminated from the University or eligibility for coverage ends (or any other period described in the Schedule of Benefits). The Company is under no obligation to refund any premium paid by University or any Subscriber, if payment was made to Company due to University's failure to timely notify 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 Company to terminate a Member's coverage or that of any of 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, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the University will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual to continuation coverage in a separate process.

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 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 a Subscriber's 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. Assignment

1. The Subscriber's rights and Benefits payable under this Benefit Plan are personal to the Subscriber and may not be assigned in whole or in part by the Subscriber. We will recognize assignments of Benefits to both Hospitals and Providers if this Benefit Plan 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 the Subscriber may be liable for the cost of medical care, treatment, or services.

2. We reserve the right to pay Network Providers directly instead of paying the Subscriber.

L. 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 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 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.

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 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.

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

O. 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.

P. 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 amount.

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 or her or her own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible amount and Coinsurance amount.

Q. 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.

R. 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") 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, 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 the lower of:

   - the billed charges for Your Covered Services; or
   - the negotiated price that the Host Blue makes available to Us.

   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 over- 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

   a. BlueCard® Program

      If You receive Covered Services under a Value-Based Program inside 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.

   If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard® service area, You should call the Blue Cross Blue Shield Global® Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, 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 assistance, Hospitals will not require You to pay for covered Inpatient services, except for Your Deductible and Coinsurance. In such cases, the Hospital will submit Your Claims to the Blue Cross Blue Shield Global® Core service center to begin Claims processing. However, if You paid in full at the time of service, You must submit a Claim to receive reimbursement for Covered Services. You must contact Us to obtain Authorization for non-Emergency Inpatient services, as explained in the Care Management Article of this Contract.

   b. Outpatient Services

      Physicians, Urgent Care Centers and other Outpatient Providers located outside the BlueCard® service area will typically require You to pay in full at the time of service. You must submit a Claim to obtain reimbursement for 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 obtain reimbursement. For institutional and professional Claims, You should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core service center at the address on the form to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of Your Claim. The claim form is available from Us, the Blue Cross Blue Shield Global® Core service center, or online at **www.bcbsglobalcore.com**. If You need assistance with Your Claim submission, You should call the Blue Cross Blue Shield Global® Core Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

ARTICLE X. 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 procedure. 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

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:

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

A response will be mailed to 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 an 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 determination. We will conduct an Informal Reconsideration within one (1) working day of Our receipt of the request.

B. Standard Appeal Procedures

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

We offer the Member two (2) levels of Appeal. If a Member is an ERISA Member, the Member is required to complete the first level of Appeal prior to instituting any civil action under ERISA section 502(a). The second level of Appeal is voluntary. Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary Appeal is pending. The Member's decision whether or not to submit to this voluntary level of review will have no effect on the Member's rights to any other Benefits under the plan. No fees or costs will be imposed on the Member.

The Member should contact his Employer, Plan Administrator, Plan Sponsor, or Our customer service department at 1-800-599-2583 or 1-225-291-5370 if the Member is unsure whether ERISA is applicable.

The Member may also call Our customer service department if they have questions or need assistance putting their Appeal in writing.

C. Standard Appeal Process

We will determine if a Member's Appeal is an administrative Appeal or a medical Appeal. The Appeals procedure has two (2) levels, including review by a committee at the second level on an Administrative Appeal and a review by an external Independent Review Organization (IRO) on 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 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 of Coverage, 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 and Grievance Unit
P. O. Box 98045
Baton Rouge, LA 70898-9045

a. First Level Administrative 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 Our initial Adverse Benefit Determination for first level administrative Appeals. Requests submitted to Us after one hundred eighty (180) days of receipt of Our initial Adverse Benefit Determination will not be considered.

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

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.

b. Second Level Administrative Appeals

After review of Our first level Appeal decision, if a Member 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.

A Member Appeals Committee of persons not involved in previous decisions regarding the initial Adverse Benefit Determination will review the second level Appeals. The Committee's decision is final and binding.

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

Second Level Administrative Appeals are not applicable to a Rescission of Coverage, which follows the External Appeals track.

2. Medical Appeals

Medical Appeals involve Adverse Benefit Determinations for 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

If a Member is not satisfied with Our decision, a written request to Appeal must be submitted within one hundred eighty (180) days of Our initial Adverse Benefit Determination for internal medical Appeals. Requests submitted to Us after one hundred eighty (180) days of Our initial Adverse Benefit Determination will not be considered.

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 of Coverage

For medical Appeals and Rescission of Coverage, 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 still disagrees with the internal medical Appeal decision or Rescission of Coverage, a written request for an External Appeal must be submitted within one hundred twenty (120) days of receipt of the internal medical Appeal decision or Rescission of Coverage.

Requests submitted to Us after one hundred twenty (120) days of receipt of the internal medical Appeal decision or Rescission of Coverage 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.

You may contact the Commissioner of Insurance directly for assistance:

Commissioner of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

D. Expedited Appeals

The expedited Appeal process is available for review of the 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 service for a Member currently in the emergency room, 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, his 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 Appeal request that meets the criteria for Expedited Appeal. In any case where the internal Expedited 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 and timeframe

2. Expedited External Medical Appeal

   An Expedited External Appeal is a request for immediate review, by an Independent Review Organization (IRO). The request may be simultaneously filed with a request for an internal Expedited Appeal, since the Independent Review Organization assigned to conduct the expedited external 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 Appeal requests to the IRO so the review may be completed within seventy-two (72) hours of receipt.

ARTICLE XI. HOW TO MAKE POLICY 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.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 in Your ID Card.

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. Preferred 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 Subscriber's Blue Cross and Blue Shield ID card shows the way the name of the Subscriber (Subscriber of the University) appears on Our records. The ID card also lists the Subscriber's Benefit Plan 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 Benefit Plan 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 Subscriber and the Provider.

Claim's Questions

Subscribers can view information about the processing or payment of a Claim online at www.bcbsla.com, 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 they have the information at hand--particularly the Benefit Plan number, patient's name and date of service.

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

* Blue Cross and Blue Shield of Louisiana has Local Service Offices located in Baton Rouge, New Orleans, Lake Charles, Lafayette, Alexandria, Monroe and Shreveport.

ARTICLE XII. 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 University

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 Contract 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 group health 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 University 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 or 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 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. Company will not accept premium payments by third parties unless required by law to do so. The fact that Company may have previously accepted a premium from an unrelated third party does not mean that Company will accept premiums from these parties in the future.

3. The Company offers a grace period of at least thirty (30) days from the date 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. Any termination of this Benefit Plan 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 date of cancellation.

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. 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, 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 anytime during the life of the Benefit Plan. Additionally, We reserve the right to increase the premium amount because of: (1) any change in age or geographic location of any individual insured or policyholder; (2) a change in the extent or nature of the risk of the University; or (3) 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.

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, 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 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 – 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.

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 Subscribers 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 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 the third Tuesday in February or on the next business day following, if a legal holiday. 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.

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 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 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 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)