# Vision

GROUP LIMITED BENEFIT CONTRACT

Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company.

40XX1663 R01/19

Louisiana

Thank you for choosing us!

It is my pleasure to welcome you to your new plan. If you are renewing your plan, welcome back! We are honored you chose the Cross and Shield for your health insurance needs. Please read this booklet for important information about your plan and how it works. If you have questions, we are here to help. Simply call the number on your ID card and we'll do our best to assist you.

My best to you,

I. Steven Udvarhelyi, M. D.
President and Chief Executive Office

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company

40XX1663 R01/19

**GROUP LIMITED VISION BENEFIT PLAN**

**THIS IS A LIMITED BENEFIT PLAN – READ CAREFULLY**

provided by


P.O. Box 98029 • Baton Rouge, Louisiana • 70898-9029

**www.bcbsla.com**

## NOTICES

We base Our payment of Benefits for the Member's covered services on an amount known as the Allowable Charge. The Allowable Charge depends on the specific Provider from whom a Member receives covered services.

**GROUP LIMITED VISION BENEFITS CONTRACT**

**TABLE OF CONTENTS**


| | | |
|---|---|---|
| **ARTICLE I.** | **UNDERSTANDING THE BASICS OF YOUR COVERAGE** | **4** |
| **ARTICLE II.** | **DEFINITIONS** | **5** |
| **ARTICLE III.** | **SCHEDULE OF ELIGIBILITY** | **11** |
| **ARTICLE IV.** | **COVERED VISION BENEFITS** | **17** |
| **ARTICLE V.** | **DISCOUNTS** | **19** |
| **ARTICLE VI.** | **SALES TAXES ON COVERED OR DISCOUNTED ITEMS** | **19** |
| **ARTICLE VII.** | **EXCLUSIONS** | **19** |
| **ARTICLE VIII.** | **BENEFITS NOT ASSIGNABLE** | **21** |
| **ARTICLE IX.** | **CONTINUATION OF COVERAGE RIGHTS** | **21** |
| **ARTICLE X.** | **GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS** | **26** |
| **ARTICLE XI.** | **COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES** | **34** |
| **ARTICLE XII.** | **ERISA RIGHTS** | **37** |
| **ARTICLE XIII.** | **MAKING PLAN CHANGES AND FILING CLAIMS** | **38** |
| **ARTICLE II.** | **GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY** | **40** |

## ARTICLE I. UNDERSTANDING THE BASICS OF YOUR COVERAGE

Blue Cross and Blue Shield of Louisiana (Company) issues this Benefit Plan to the Group/Policyholder, as shown in the Schedule of Vision Benefits. A copy of this Benefit Plan provided to Subscribers serves as the Subscriber's certificate of coverage.

The vision Benefits available under this Benefit Plan are described in Article IV. The Schedule of Vision Benefits controls in regards to the Benefits covered, the frequency with which they are covered, and the cost sharing applicable to each Benefit, among other things. A Subscriber must meet the employer's Eligibility Waiting Period before coverage is effective on this Benefit Plan. The Group may apply to the Company to change the covered Benefits on the Group's anniversary date. Benefits offered may be limited.

As of the later of the Original Effective Date or the Amended Effective Date of the Benefit Plan shown in the Group's Schedule of Vision Benefits, We agree to provide the vision Benefits specified herein for Subscribers of the Group and their enrolled Dependents. This Benefit Plan replaces any others previously issued to the Group/Policyholder. A word used in the masculine gender applies also in the feminine gender, except where otherwise stated.

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."

### THE DAVIS VISION NETWORK

Davis Vision, Inc. (hereinafter, "Davis Vision) is the Company's network and claims administrator for this Benefit Plan, and is in charge of managing the Davis Vision Network, handling and paying claims, and providing customer services to the Members eligible to receive coverage under this Benefit Plan.

The Davis Vision Network consists of a select group of Providers who have contracted with Davis Vision to render services to Members for discounted fees. **All other Providers are considered Non-Participating. THIS BENEFIT PLAN COVERS SERVICES OR MATERIALS RECEIVED FROM NON-PARTICIPATING PROVIDERS AT THE REDUCED BENEFITS SPECIFIED IN THE SCHEDULE OF VISION BENEFITS.**

**In order to receive the full benefits under this section, the Member should verify that a Provider is a Davis Vision Network Participating Provider before any service is rendered.** To locate a Participating Provider and verify their continued participation in the Davis Vision Network, or to ask any questions related to Benefits or claims, please visit the website at [**www.bcbsla.com**] or contact a customer service representative at [1-800-247-9368].

### HOW THE COMPANY DETERMINES WHAT IT PAYS FOR COVERED SERVICES

The Company bases its payment of Benefits for a Member's Covered Services on an amount known as the "Allowable Charge." The Allowable Charge is determined according to Davis Vision's fee schedule for each covered Benefit. If the amount that is billed for Covered Services by the Member's Provider is less than the amount that Davis Vision has set for the Covered Service, the billed amount is the Allowable Charge and the Company's payment will be based on the billed amount.

**NOTICE: THE MEMBER'S SHARE OF THE PAYMENT FOR COVERED SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN THE MEMBER'S PLAN AND THE MEMBER'S PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW THE MEMBER'S PROVIDER TO BILL THE MEMBER FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.**

## ARTICLE II. DEFINITIONS

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 is determined to be experimental or investigational;

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

C. any prospective or retrospective review determination.

Allowable Charge – The lesser of the billed charge or the amount established by Davis Vision as the maximum amount allowed for all Provider services covered under the terms of this Benefit Plan.

Appeal – A written request from a Member or authorized representative to change an Adverse Benefit Determination made by Davis Vision.

Authorization (Authorized) – A determination by Davis Vision that, based on the information provided, a Benefit satisfies the clinical review criteria requirement for Medical Necessity, appropriateness of the healthcare setting, or level of care and effectiveness. An Authorization is not a guarantee of payment.

Benefit(s) – Coverage for the benefits as described in Article IV and the Schedule of Vision Benefits. Benefits provided by the Company are based on the Allowable Charge.

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

Benefit Plan – This contract, including the application for Group vision coverage, the Schedule of Vision Benefits and amendments/endorsements, if any, entitling the Subscriber and enrolled Dependents to specified Benefits.

Benefit Plan Date – The date upon which the Group agrees to begin providing Benefits for Covered Services to Members on this Benefit Plan.

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

Blended-Segment Lenses – Lenses containing two different posers, one for distance, and one for near. Segment with near prescription is invisible.

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

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

Collection Frames – Refers to Eyeglass Frames offered to Members by certain private practice Participating Providers at zero to little out-of-pocket cost. There are three tiers of Collection Frames: Fashion, Designer and Premier, any of which may be selected in place of using the retail frame allowance. Other Network Providers that do not have an agreement with Davis Vision to offer the Collection must offer a similar selection of frames with a comparable retail value.

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

Complaint – An oral expression of dissatisfaction with the vision plan or Provider services.

Concurrent Review – A review of Medical Necessity, appropriateness of care, or level of care conducted during a course of treatment.

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

Cosmetic Surgery/Treatment – Any procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

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

Creditable Coverage – Prior coverage of vision benefits similar to those covered under this Benefit Plan under an individual or group health plan including, but not limited to, Medicare, Medicaid, government plan, church plan, COBRA, or military plan. Creditable coverage does not include specific disease policies (i.e., cancer policies), supplemental coverage (i.e., Medicare Supplement, Medigap) or limited benefits (i.e., accident only, disability insurance, liability insurance, workers' compensation, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics or coverage as specified in federal regulations under which benefits for medical care are secondary or incidental to the insurance benefits).

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

Designer Level Frames – A selection of Collection Frames available exclusively at contracted private practice Providers with a retail value of more than $125.00 but not to exceed $175.00.

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

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

Eligibility Waiting Period – The period established by the employer that must pass before an individual is eligible to become covered under this Benefit Plan. If an individual enrolls as a Special Enrollee, any period before such Special Enrollment is not a waiting period. A Subscriber must satisfy any Eligibility Waiting Period established by the Group before vision coverage is effective.

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

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

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

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.

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

Fashion Level Frames – Selection of Collection Frames available exclusively at contracted private practice Providers with a retail value up to $125.00.

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

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

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

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

Group – Any company, partnership, corporation or other legal entity which has made application for coverage herein and has agreed to comply with all the terms and requirements of this Benefit Plan. For the purposes of this Benefit Plan, the Group is the policyholder.

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

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

Investigational – A vision 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 vision practice. Any determination We make that a vision treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. whether the vision 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 vision treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. whether the vision 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, 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 or vision literature generally recognized by the relevant vision community; or

    3. reference to federal regulations.

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

Medically Necessary (or "Medical Necessity") – Vision care 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 or vision 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 or vision literature generally recognized by the relevant vision health services community recommendations and the views of Ophthalmologists or Optometrists practicing in relevant clinical areas and any other relevant factors.

Medically Necessary Contact Lenses – Contact lenses that are determined as Medically Necessary in the treatment of the following conditions: Keratoconus, Anisometropia, Corneal Disorders, Pathological Myopia, Aniseikonia, Post-Traumatic Disorders, Aphakia, Aniridia and Irregular Astigmatism. In general, Medically Necessary Contact Lenses may be prescribed in lieu of eyeglasses, when it will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

Member – A Subscriber or an enrolled Dependent.

Monocular Patient – Refers to only one eye of the patient or one side of a prism binocular.

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

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

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

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

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

Premier Level Frames – Selection of frames from the Davis Vision Collection available exclusively at contracted private practice Providers with a retail value of more than $175.00 but not to exceed $225.00.

Premium Anti-Reflective Coating – Advanced forms of Anti-Reflective Coatings for Spectacle Lenses with improved durability.

Premium Progressives – Lenses are often referred to as "free-form design" or "wave-front technology" to help minimize peripheral distortion.

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

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

Premium High-Index Lenses – Material with a higher index of refraction than plastic and standard High-Index typically used for more significant vision correction prescriptions.

Premium Progressive Lenses – Lenses with continuously variable power zones from far distance to near distance correction with a newer, branded progressive lens design or a proprietary, digitally manufactured design.

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

A. Participating Provider – A Provider that has a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member. This Provider may also be referred to as a "Network Provider."

B. Non-Participating Provider – A Provider that does not have a Provider Agreement with Davis Vision pertaining to payment for Covered Services rendered to a Member. This Provider may also be referred to as a "Non-Network" or "Out-of-Network" Provider.

Provider Agreement – An agreement for payment contracted by Davis Vision with Participating Providers. These agreements establish the actual payments which will be made to the Participating Provider. The payments may reflect a discount or payment formula that has been contracted between Davis Vision and the Participating Provider.

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

- Case history (chief complaint, eye and vision history, medical history)
- Entrance distance and near acuities, with and without current lenses
- External ocular evaluation
- Internal ocular examination
- Tonometry
- Refraction (objective and subjective)
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan
- Advising the patient on matters pertaining to vision care
- Form completion (e.g. school, motor vehicle)
- A Dilated Fundus Examination (DFE) when professionally indicated (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertention and other ocular and/or systematic diseases)

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

Scratch-Resistant Coating – Coating applied to spectacle lenses to increase the scratch resistance of the lens surface.

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

Special Enrollee – An Eligible Person who is entitled to and who requests special enrollment (as described in this Benefit Plan) within thirty (30) days of losing other certain vision coverage or acquiring a new Dependent as a result of marriage, birth, adoption or placement for adoption.

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

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

Spouse – The Subscriber's legal Spouse.

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

Standard High-Index Lenses – Material with a higher index of refraction than plastic, which is used to create lenses that are thinner (by almost one-third) and flatter than what is possible with normal plastic.

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

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

Subscriber – An Eligible Person who has satisfied the specifications of this Benefit Plan's Schedule of Eligibility and has enrolled for coverage, and to whom the Company has issued a copy of this Benefit Plan.

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

Ultra Anti-Reflective Coating – Non-glare, clear lens coating that limits light reflection, which allows the maximum amount of light to pass through the lens and provides anti-reflection protection. The ultra-coating uses the latest lens material technologies with all the benefits of both standard and premium lenses, and includes a top-tier scratch-resistance coating, such as Crizal Avance™ or equivalent.

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

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

## ARTICLE III. SCHEDULE OF ELIGIBILITY

### A. Eligibility

1. Subscriber. To be eligible to enroll as a Subscriber, an individual must be:

   a. an employee, who has satisfied any criteria designated by us, has satisfied any Eligibility Waiting Period required by the Group, and who is working the number of hours designated by the Company in the Application for Group Coverage.

   b. a retiree who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Vision Benefits.

   c. an elected official who satisfies any criteria designated by Us, and if shown as covered in this Group's Benefit Plan Schedule of Vision Benefits.

2. Dependent. To be eligible to apply as a Dependent, an individual must meet the following criteria at the time of enrollment. To be eligible to maintain Dependent coverage, an individual must continue to meet the criteria. Failure to continually meet the criteria thereafter may result in a determination by the Company that the Dependent is no longer eligible for coverage and Dependent Benefits may be terminated in the manner described in this Benefit Plan:

   a. Spouse.

   b. CHILDREN: A child under age twenty-six (26) who is one of the following:

      (1) born of the Subscriber; or

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

      (3) legally adopted by the Subscriber; or

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

      (5) a child supported by the Subscriber pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN); or

      (6) a stepchild of the Subscriber; or

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

      (8) the Subscriber's child after attaining age 26, or grandchild who was in the legal custody of and residing with the Subscriber before attaining age 26, who is incapable of self-sustaining employment by reason of being mentally or physically disabled prior to attaining age twenty-six (26). The Subscriber must furnish Us with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's twenty-sixth (26th) birthday. We may require subsequent proof once a year after the initial two-year period following the child's twenty-sixth (26th) birthday.

### B. Application for Coverage

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

2. The Group will submit any such enrollment forms to the Company as a prerequisite to coverage under this Benefit Plan.

3. No person will be covered under this Benefit Plan unless the Company has accepted the enrollment form and has been issued an identification card or other written notice of acceptance. Payment of premiums to the Company for any person will not effectuate coverage unless and until the Company's identification card or other written acceptance has been issued, and in the absence of such issuance, the Company's liability will be limited to refund of the amount of premiums paid.

4. This Group vision Benefit Plan and coverage under it will not be issued or renewed unless the percentage of Eligible Persons specified in the Application for Group Coverage is enrolled.

**C. Available Classes of Coverage as Selected by the Group**

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

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

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

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

5. Subscriber and Dependent coverage means coverage for the Subscriber and one Dependent.

**D. Effective Date**

When an enrollment form has been accepted and any premiums for coverage have been paid, coverage will begin on the following applicable Effective Date, subject to any Eligibility Waiting Period:

1. If a person is an Eligible Person on the Group's Benefit Plan Date and enrolls for coverage for self or for self and any eligible Dependent(s) on or before such date, this Group's Benefit Plan Date will be the Effective Date of coverage.

2. If a person becomes an Eligible Person after this Group's Benefit Plan Date, and enrolls for coverage for self or for self and any eligible Dependent(s) and the enrollment form is received by the Company within thirty (30) days of the eligibility date, the Effective Date of coverage will be the eligibility date.

3. If an Eligible Person’s application for coverage for self or for self and any eligible Dependent(s) is not received by Us within thirty (30) days of the eligibility date or Special Enrollment Period as described below, the request for enrollment will be denied. The Eligible Person shall be eligible to enroll for coverage during the next Open Enrollment Period.

4. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), and the enrollment form is received by the Company within one hundred eighty (180) days of the date of birth, the Effective Date of coverage will be the date of birth.

**E. Court Ordered Determination**

If a court ordered determination is made to cover an eligible Dependent under an employee’s Benefit Plan, the employee must enroll himself, if not already enrolled, and enroll the eligible Dependent by completing an enrollment form and submitting the enrollment form to Our home office within thirty (30) days after the court ordered determination. If timely enrolled, coverage for the eligible Dependent will be effective on the date of the court ordered determination.

## F. Special Enrollment

1. Special Enrollment Due to Loss of Certain Other Vision Coverage

   Special Enrollment Rights due to loss of certain other vision coverage are available only to current employees or elected officials and their Dependents. These rights are not available to retirees.

   Individuals who lose other coverage because they do not pay their premium or required contributions or lose other coverage for cause (such as filing fraudulent claims or an intentional misrepresentation of a material fact in connection with the plan) are not Special Enrollees and have no special enrollment rights.

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

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

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

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

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

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

         (a) the full COBRA continuation period was exhausted;

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

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

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

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

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

            (i) loss of eligibility as a result of legal separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the hours of employment;

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

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

(iv) an individual incurs a Claim that meets or exceeds a Lifetime Maximum of all Benefits; or

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

(vi) termination of employer contributions to the other coverage.

A Special Enrollee under this section must request enrollment for coverage under this Benefit Plan within thirty (30) days after other coverage ends (or after the employer stops contributing toward the other non-COBRA coverage). If such enrollment is received by a Blue Cross and Blue Shield of Louisiana office within thirty (30) days after loss of other coverage, coverage will become effective on the date other coverage is lost. If the enrollment is not received within thirty (30) days of the loss of other coverage, but is received within sixty (60) days of loss of other coverage, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. Coverage will not be available if Blue Cross and Blue Shield of Louisiana does not receive the request for enrollment form within sixty (60) days of the loss of other coverage. An Eligible Person whose coverage was not under COBRA has thirty (30) days after a Claim is denied due to the operation of a lifetime limit on all Benefits to enroll for coverage, and may request special enrollment from the date such Claim is denied. An Eligible Person whose coverage was under COBRA has thirty days after the Claim is incurred due to the operation of a lifetime limit on all Benefits to enroll for coverage.

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

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

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

3. Special Enrollment Due to Acquiring a Dependent

   a. This Benefit Plan shall provide for a special enrollment period during which the Dependent of a participating employee, retiree, or elected official may be enrolled on the plan. If not already participating, a current employee or elected official may enroll with the Dependent if he has served any applicable Eligibility Waiting Period but has not enrolled during a previous enrollment period. (Retirees who are not currently participating do not have these special enrollment rights for adding Dependents and may not come on the plan for this reason.)

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

c. If the Group offers multiple vision plan options, another option may be chosen by the current employee, retiree or elected official for himself and Dependents when Special Enrollee status applies.

d. There is a thirty (30) day period of automatic coverage for Newly-Born Infants (natural born or adopted), as described below. Any period of automatic coverage runs concurrently with the Special Enrollment Period for adding these infants to this Benefit Plan.

e. The Special Enrollment Period described in this subparagraph is a period of no less than thirty (30) days and shall begin on the later of the date Dependent coverage is made available or the date of the marriage, birth, adoption, or placement for adoption. If the request for enrollment is not made timely, the request will be denied and any period of automatic coverage will end.

f. In the case of a birth, adoption, or placement for adoption, a current employee may enroll himself, his Spouse and/or the newborn/adopted child. The enrollment must be requested by signing an enrollment form no later than thirty (30) days after the birth, adoption, or placement for adoption. If the enrollment form is received by a Blue Cross and Blue Shield of Louisiana office no later than thirty (30) days of the birth, adoption, or placement for adoption, coverage will become effective on the date of birth for a natural Newly Born Infant, and upon the date of adoption or placement for adoption for an adopted Newly Born Infant. A Subscriber may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth. Adopted children will not be effective on the date of birth. If the signed enrollment form is not received by Us within thirty (30) days of birth, adoption or placement for adoption, any automatic coverage period will end. If the signed enrollment form is not received by Us within thirty (30) days of birth, adoption or placement for adoption, but is received within sixty (60) days of birth, adoption or placement for adoption, coverage will begin no later than the first day of the calendar month beginning after We receive the request for special enrollment. No coverage will be available if the enrollment form is not signed within thirty (30) days of the birth, adoption, or placement of adoption. Coverage will not be available if We do not receive the enrollment form within sixty (60) days of birth, adoption, or placement for adoption.

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

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

a. If a child is born to a Subscriber holding Subscriber Only coverage or Subscriber and Spouse coverage, the following will apply:

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

(2) If the completed Employee Enrollment / Change Form is not received within this period, coverage for the child will terminate upon the expiration of the automatic coverage period. Any later request to add coverage for the child must be made at open enrollment or under a special enrollment provision.

b. If a child is born to a Subscriber holding coverage which includes Dependent children (Subscriber and Family coverage or Subscriber and Child(ren) coverage), the Effective Date for coverage for such child will be the date of birth. You must notify Us within one hundred eighty (180) days of the birth to update Our records.

5. Automatic Coverage Period for Newly Born Adopted Infants

a. For Members holding Subscriber Only coverage or Subscriber and Spouse coverage:

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

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

(2) If the completed Employee Enrollment / Change Form is not received within this period of automatic coverage, coverage for the infant will terminate upon the expiration of the period of automatic coverage. Any later request to add coverage for the child may be made at open enrollment or under a special enrollment provision.

b. For Members holding Subscriber and Family coverage or Subscriber and Child(ren) coverage:

If within thirty (30) days of the birth of a child, the Newly Born Infant is either: legally placed into the Subscriber's home for adoption following a voluntary act of surrender, or if an ill newborn, from the date the child could have been legally placed into the Subscriber's home had he not been ill, to the custody of the Subscriber or his legal representative which becomes irrevocable, or is subject to a court order awarding custody to a Subscriber holding coverage which includes Dependent children, the Effective Date of coverage of the adopted Newly Born Infant will be the date of placement into Subscriber's home or the date of the custody order. The child will not be effective from birth. You must notify Us within one hundred eighty (180) days of the date of placement in the home or of the custody order to update Our records.

## ARTICLE IV. COVERED VISION BENEFITS

The Schedule of Vision Benefits will be controlling regarding which of the Benefits described in this Article are covered under the Member's plan, with what frequency, which copayments or coinsurance apply, and what limitations apply to them. Please refer to the Schedule of Vision Benefits for details.

### A. Network Benefits

Members will have coverage for a Routine Eye Examination according to the terms of Schedule of Vision Benefits and as described below. In addition to the Routine Eye Examination, Members may have coverage for materials or laser vision correction services, as described below. The Schedule of Vision Benefits will state if the Member has coverage for materials and laser vision correction services.

1. Routine Eye Health Examination

   After Member's payment of any applicable copayment stated on the Schedule of Vision Benefits, the Company will cover one Routine Eye Health Examination. Covered Routine Eye Health Examinations will include dilation of eye pupils when professionally indicated. Routine Eye Health Examinations will be limited to the frequency stated in the Schedule of Vision Benefits.

2. Materials

   a. Prescription Spectacle Lens For Each of the Members Eyes

      After Member's payment of any applicable copayment, the Company will cover one prescription Spectacle Lens for each of Member's eyes, as stated in the Schedule of Vision Benefits. The type of lens materials covered will be explained in the Schedule of Vision Benefits. Prescription Spectacle Lens coverage will be limited to the frequency stated in the Schedule of Vision Benefits.

      The Member may be able to enhance the Spectacle Lenses covered above at discounted prices. The Schedule of Vision Benefits may include discounted prices for some special types of lens materials and other enhancements. Any available enhancement options are not to be considered coverage under this Benefit Plan.

   b. Eyeglass Frames

      After Member's payment of any applicable copayment stated in the Schedule of Vision Benefits, the Company will cover one eyeglass frame, up to any maximum allowance specified in the Schedule of Vision Benefits. Certain private practice Participating Providers carry the Davis Vision Frame Collection, which the Member can get with little or no out-of-pocket costs, as stated in the Schedule of Vision Benefits. To know which Providers that carry the Collection Frames, please visit our website at **www.bcbsla.com** to search for the Davis Vision Providers near You. Providers that carry the Collection Frames will have an indicator to that effect.

      All Eyeglass Frames coverage will be limited to the frequency stated in the Schedule of Vision Benefits.

   c. Prescription Contact Lenses

      After Member's payment of any applicable copayment stated in the Schedule of Vision Benefits, the Company will cover one prescription Contact Lens for each of the Member's eyes, up to the maximum allowance indicated in the Schedule of Vision Benefits.

      The Schedule of Vision Benefits will also indicate if the Contact Lenses coverage will be in lieu of or in addition to eyeglasses. If the Contact Lenses coverage is "in lieu of eyeglasses" it means that, within the frequency period stated in the Schedule, the Member may only choose one of either prescription Spectacle Lenses and an Eyeglass Frame, or Contact Lenses, but not both. If to the contrary, the Contact Lenses coverage is "in addition to eyeglasses", it means that the Member may

choose prescription Spectacle Lenses and an Eyeglass Frame, and Contact Lenses within the same frequency period.

3. Laser Vision Correction Services

Laser vision corrections are surgical procedures to correct vision problems such as nearsightedness, farsightedness and astigmatism. Laser vision corrections will only be covered if they are included in the Schedule of Vision Benefits. Members will have coverage for the specific laser vision correction procedures stated in the Schedule of Vision Benefits, and subject to the cost sharing specified.

Authorization must be obtained prior to surgery. The Member or attending Provider must send a completed request to Davis Vision prior to the initial evaluation. If the required Authorization is not obtained, the entire charge for such services will be the Member's responsibility.

Surgery must be performed within the time frame from the preoperative examination stated in the Schedule of Vision Benefits. If a Member does not obtain the surgery within this time period and another pre-operative examination is necessary, the cost of that examination will not be covered under this Benefit Plan.

If according to the Schedule of Vision Benefits the Member's plan does not cover Laser Vision Correction Services, Members could have a discount for such services through Davis Vision. Please ask Davis Vision for details.

**B. Limitations for Network Benefits**

1. Medically Necessary Contact Lenses

Medically Necessary Contact Lenses are subject to Authorization. Once Authorized, the Member will be able to choose any of the contact lens options available under this Article, subject to any corresponding copayment and allowance. Medically Necessary Contact Lenses that are not duly Authorized will not be covered.

2. Collection and non-Collection Eyeglass Frames

Members may choose either one Collection or one non-Collection Eyeglass Frame within their frequency period, but not both.

3. Eyeglass Frame and Contact Lens Coverages Subject to an Allowance

When according to the Schedule of Vision Benefits, Eyeglass Frame or Contact Lens coverage is limited to a maximum allowance, that means that those items are covered, after their corresponding copayment, up to their retail value stated in the Schedule. If the Member chooses an item which retail value exceeds the allowance, the Member will have to pay the excess in addition to the applicable copayment. The Member may be given a discount from the frame's or lenses' retail value in excess of the allowance. Any discounts over an item's retail value in excess of the allowance will not be available if the Member purchases his/her item from a Costco, Walmart or Sam's Club location. Eyeglass Frames purchased at Visionworks locations may have a higher maximum allowance than if purchased from other locations, if so stated in the Schedule of Vision Benefits.

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

Evaluation, Fitting and follow-up care coverage for Contact Lenses are described in the Schedule of Vision Benefits. Evaluation, Fitting and follow up care may not be covered for certain types of contact lenses, may be covered in full subject to a copayment, or may be covered up to a specific fee value (the "allowance"). Evaluation, Fitting and follow-up care fee values which exceed the allowance will require the Member to pay the excess fee in addition to any applicable copayments and any other fees. Discounts over Evaluation and Fitting fees in excess of any allowance may be available. Any discounts

will not be available if the Member purchases his/her Contact Lenses from a Costco, Walmart or Sam's Club location.

### C. Out-of-Network Benefits

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

Davis Vision will reimburse the Member for services and materials rendered by Non-Participating Providers. The Member will be responsible to pay the Non-Participating Provider for its charges in full, and then submit the claim to Davis Vision for reimbursement up to the limits stated in the Schedule of Vision 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 VISION BENEFITS.**

## ARTICLE V. DISCOUNTS

Members may have access to discounts on vision-related services and materials not covered under this Benefit Plan. All discounts, including those described in the Schedule of Vision Benefits as related to covered Benefits, are administered and provided by Davis Vision in consideration of the Member being covered under this Benefit Plan. Discounts are not to be considered coverage under this Benefit Plan. The Member may have access to even more discounts than those described in the Schedule of Vision Benefits because of being a Davis Vision client. Davis Vision may change or discontinue the discounts provided to their clients in the regular course of business without notice. Members must consult with Davis Vision or a Davis Vision Provider to find out what discounts are available to them at any specific time.

## ARTICLE VI. SALES TAXES ON COVERED OR DISCOUNTED ITEMS

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

## ARTICLE VII. EXCLUSIONS

Any of the limitations and exclusions in this Benefit Plan may be revised, deleted or limited as shown in the Schedule of Vision Benefits.

Unless otherwise shown as covered in this Benefit Plan, no Benefits will be provided for the following,

**REGARDLESS OF CLAIM OF MEDICAL NECESSITY**:

1. Services, supplies, treatments for services that are not specifically stated as covered under this Benefit Plan and complications from services, supplies and treatments that are not covered under this Benefit Plan.

2. Services, treatments, procedures, equipments, 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.

3. Services or materials from Providers not participating in the Davis Vision Network.

4. Any charges exceeding the Allowable Charges.

5. Any medical or surgical service not specifically covered under this Benefit Plan.

6. Benefits received from a vision or a medical department or Provider maintained by or on behalf of a Group or employer, a mutual benefit association, labor union, trust, or similar person or Group.

7. Services or expenses for which the Member has no obligation to pay, or for which no charge would be made if the Member had no vision coverage.

8. Services rendered as a result of occupational disease or injury compensable under any Workers' Compensation Law subject to the provisions of L. R. S. 23:1205(C). This exclusion shall not apply to services rendered to a Member holding fifty percent (50%) or more ownership in the Group (or an employer, if Group is an association of employers), if the Member has legally opted to be excluded from Worker's Compensation coverage for the Group and has furnished the Company with written verification of his or her ownership interest and exclusion from Worker's Compensation coverage at the time of enrollment or upon acquisition of the required ownership percentage.

9. Services for which payment is available under the laws of the United States, any of its states or political subdivisions or the Veterans Administration, except where enforcement of this exclusion is prohibited by law.

   Services in the following categories:

   a. those for diseases contracted or injuries sustained as a result of war, declared or undeclared or any act of war;

   b. those for injuries or illnesses found by the Secretary of Veteran's Affairs to have been incurred in or aggravated during the performance of service in the uniformed services;

   c. those occurring as a result of taking part in a riot or acts of civil disobedience;

   d. those occurring as a result of a Member's commission or attempted commission of a felony. This exclusion does not apply to the extent inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Benefits are available to the Member for illness or bodily injury due to an act of domestic violence or a medical condition (including both physical and mental health conditions) or in case of emergency care, the initial medical screening examination, treatment and stabilization of an emergency condition; or

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

10. Vision services or materials incurred or received before the Member's Effective Date.

11. Benefits after the termination or cancellation of the Benefit Plan, regardless of the cause of termination or cancellation.

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

13. Surgical treatments for vision correction, unless otherwise specifically covered under this Benefit Plan.

14. Services or materials other than those specifically listed in the Schedule of Vision Services and described under Article IV of this Benefit Plan.

15. Services, materials, supplies, or charges to the extent payment has been made or is available under any other contract issued by this or any other Blue Cross or Blue Shield Company, or to the extent provided for under any other group benefit plan.

16. Services, materials or supplies 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.

17. Services, materials, supplies, equipment, or charges in connection with Cosmetic Surgery/Treatment.

18. Any sales taxes or interest.

19. Care rendered by a Provider who is the Member's Spouse, child, stepchild, parent, stepparent or grandparent.

20. Charges for telephone or email consultations, failure to keep a scheduled visit, completion of a Claim form, to obtain medical records or information required to adjudicate a Claim, or for access to or enrollment in or with any Provider.

21. Anesthesia.

22. Services in connection with diagnostic photos (i.e., Polaroid).

23. Services or supplies determined by the Company to be not Medically Necessary.

## ARTICLE VIII. BENEFITS NOT ASSIGNABLE

All Benefits payable by the Company under this Benefit Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member. The Company will not recognize a Member's attempted assignment to or direction to pay any Providers. Nothing contained in this Benefit Plan shall be construed to make this vision plan or Us liable to any third party to whom a Member may be liable for provided vision services or materials.

## ARTICLE IX. CONTINUATION OF COVERAGE RIGHTS

### A. State Continuation

This section (State Continuation) is available only if the Group is not subject to Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto.

A Subscriber or covered Dependent whose coverage under this Contract ends because of: 1) Subscriber's death; or 2) Subscriber's termination of active employment; or 3) because of the divorce of the Subscriber or a covered Member, may be entitled to continue the coverage under this Contract. The Subscriber or Dependent requesting continuation must have been continuously covered under this Contract (or another group policy that this Contract replaced) for the three (3) consecutive months immediately preceding the date this coverage would otherwise have ended.

Continuation of coverage for a Subscriber or his Dependents is not available if:

- the Covered Person, within thirty-one (31) days of termination of coverage, is or could have been covered by other Group coverage or a government sponsored health plan such as Medicare or Medicaid, or Group; or

- the Subscriber's or Member's coverage under this Contract terminated due to fraud or failure to pay his required contribution to premium; or

- the Covered Person is eligible for continuation of coverage under COBRA.

To elect continuation of coverage under this section, the Subscriber or Member must notify the Group in writing of his election to continue this Group health coverage and must pay any required contribution to the Group in advance. The initial contribution must be paid no later than the end of the month following the month in which the event occurred which made the Subscriber or Member eligible. (If the Dependent is eligible due to divorce, the event shall be deemed to have occurred on the date of the judgment of divorce.) A form to continue coverage is available from the Group.

Continuation of insurance under the Group policy for any Covered Person shall terminate on the earliest of the following dates:

- twelve (12) calendar months from the date coverage would have otherwise ended; or
- the date ending the period for which the Subscriber or Dependent makes his last required premium contribution for the coverage; or
- the date the Subscriber or Member becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured, including Medicare of Medicaid; or
- the date on which the Group policy is terminated; or
- the date on which an enrolled Member of a health maintenance organization legally resides outside the service area of the Company.

**B. COBRA Continuation**

The following provisions are applicable only if the Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto. Please refer to the Group Human Resources Manager or Benefits Manager for details about COBRA, or the applicability of COBRA to this Benefit Plan.

What is COBRA continuation coverage?

In accordance with COBRA law, the employees and eligible dependents of certain employers may have the opportunity to continue their employer-sponsored healthcare coverage for a limited time, when there is a life event (also known as a “qualifying event”) that would otherwise result in the loss of coverage under the employer’s plan. When a qualifying event causes such loss of coverage, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” The Subscriber, the Subscriber’s Spouse and the Subscriber’s dependent children are listed under the law as the qualified beneficiaries. COBRA continuation coverage offers the same coverage that the Plan gives to other participants or beneficiaries who are not receiving continuation coverage. The qualified beneficiary may be required to pay the full cost of the continuation coverage for its entire duration.

Do I have other alternatives to COBRA continuation coverage?

COBRA continuation coverage is not the only alternative Members may have when they lose coverage under this Benefit Plan. There may be other coverage options for You and Your family.

For example, You could qualify to buy individual coverage through the Health Insurance Marketplace. Losing coverage under this Benefit Plan gives You a special enrollment opportunity in the Marketplace, even when it happens outside of the Marketplace’s open enrollment period. You have sixty (60) days from when You lose coverage under this Benefit Plan to apply for special enrollment through the Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Being ligible for COBRA does not limit Your eligibility for coverage or for a tax credit through the Marketplace. However, it is important that You know that if You or any of Your Dependents choose COBRA continuation coverage instead of Marketplace coverage, You will lose the special

enrollment opportunity for the Marketplace, and You will not be able to enroll until the Marketplace's normal enrollment period opens or Your COBRA continuation coverage is exhausted.

Additionally, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within thirty (30) days from losing coverage under this Benefit Plan.

Therefore, We invite You to consider all Your options so You choose the one that better fits Your needs and budget.

What if I choose to get COBRA continuation coverage?

**If You and Your Dependents are qualified beneficiaries and choose to get COBRA continuation coverage, You must follow all notice and time period requirements described below or You will lose Your rights.** If the Group requires shorter time periods than those stated herein, the shorter time periods of the Group apply.

What are the "qualifying events"?

A "qualifying event" is any of the following events:

- termination of employment of a covered employee for reasons other than gross misconduct;
- loss of eligibility by a covered employee due to a reduction in the number of work hours of the employee;
- death of a covered Subscriber;
- divorce or legal separation between a covered Subscriber and his/her Spouse;
- the covered Subscriber becomes entitled to Medicare Benefits resulting in the loss of coverage for Dependents;
- a Dependent child ceases to be an Eligible Dependent under the terms of this Benefit Plan; or
- the employer files for a Chapter 11 bankruptcy proceeding, but only with respect to covered former employees who retired from the employer at any time.

NOTE: Special rules apply for certain retirees and their Dependents who lose coverage because of an employer's Chapter 11 bankruptcy. In this event, certain retirees may elect lifetime COBRA coverage. Eligible Dependents of retirees may continue coverage until the retiree's death. When the retiree dies, Dependents may elect an additional thirty-six (36) months of coverage from the date of the retiree's death. In all cases, these qualified beneficiaries must pay for the coverage elected. COBRA coverage under these circumstances will terminate early for a number of reasons including but not limited to: the employer ceases to provide any group health plan to any employees or the qualified beneficiaries fail to pay the required premiums or become covered under another employer's group health plan that does not exclude or limit Benefits for a qualified beneficiary's Pre-Existing Conditions. COBRA continuation coverage rights under Chapter 11 bankruptcy proceedings will be determined by the bankruptcy court, and the coverage eligible beneficiaries could receive may not be the same as the ones they had under the retiree plan before the employer filed for Chapter 11 bankruptcy.

Do I have to provide notification of any qualifying event?

The qualified beneficiary must give notice of the following qualifying events to the Group within 60 days of the event:

- divorce or legal separation,
- becoming entitled to Medicare, or
- a Dependent losing eligibility for coverage as a dependent child.

The Group will advise a qualified beneficiary of his rights under COBRA upon the occurrence of any qualifying event or following the timely notice of a qualifying event when such notice is required to be given by the qualified beneficiary.

What do I have to do to get COBRA continuation coverage?

To elect continuation coverage, the qualified beneficiary must complete a COBRA election form and furnish it to the Group timely. The option to elect continuation coverage will be offered during a period which:

- begins no later than the date on which a Member otherwise would lose coverage under the Group health plan (the "coverage end date"); and
- ends sixty (60) days after the coverage end date or sixty (60) days after the Member is notified of their right to continue coverage, whichever is the latest.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's Spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several or for all Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of the Dependent children. The employee or the employee's Spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

How much will I have to pay for COBRA continuation coverage?

A Member may be required to pay the entire cost of continuation coverage (including both employer and employee contributions) plus an amount to cover administrative expenses. If continuation of coverage is elected, the qualified beneficiary must make his first payment for continuation coverage within forty-five (45) days after the date of the election. If the qualifying beneficiary does not make the correct first payment in full within the forty-five (45) day period, all COBRA continuation coverage rights are lost. Timely monthly payments are required thereafter to keep coverage. Member may not receive notice of payments due.

When will COBRA continuation coverage begin and how long will it last?

Once elected, COBRA continuation of coverage will begin on the coverage end date and will terminate on the earliest of the following events:

- eighteen (18) months after the qualifying event in the case of termination of employment or reduction in work hours. When the employee became entitled to Medicare benefits less than eighteen (18) months before the termination of employment or reduction of work hours, continuation coverage for qualified beneficiaries other than the employee will last the longer of thirty-six (36) months from the date of Medicare entitlement or eighteen (18) months from the qualifying event; or
- thirty-six (36) months after the qualifying event when such event is other than termination of employment or reduction of work hours; or
- the date the employer ceases to maintain any Group health plan for its employees; or
- the date coverage ceases because of nonpayment of required premiums when due; or

- the date the qualified beneficiary first becomes covered under another group health plan and benefits under that other plan are not excluded or limited with respect to a Pre-Existing Condition (NOTE: There are limitations on plans imposing Pre-Existing Condition exclusions and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).; or

- the date the qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both).

Can I extend my COBRA continuation coverage?

A qualified beneficiary's right to COBRA continuation coverage will never last longer than thirty-six (36) months from the qualifying event. This maximum duration period cannot be extended, disregarding the circumstances.

Those that are receiving eighteen (18) months of continuation coverage can extend their period, as explained below, if they undergo a second qualifying event during that original eighteen (18) month period, or are declared disabled by the Social Security Administration.

If a qualified beneficiary experiences a second qualifying event other than the termination of employment or reduction of work hours while receiving eighteen (18) months of COBRA continuation of coverage, the Dependents who were qualified beneficiaries at the time of the first qualifying event, and elected COBRA continuation coverage, may qualify for up to eighteen (18) additional months of continuation of coverage, for a maximum of thirty-six (36) months. This extension may be available to Dependents receiving continuation of coverage if:

- the employee or former employee dies;

- the employee or former employee becomes entitled to Medicare (under Part A, Part B, or both);

- the employee or former employee and Dependent Spouse divorce;

- the Dependent child is no longer eligible under the Benefit Plan as a Dependent.

The second qualifying event is applicable only if the event would have caused the Dependent to lose coverage under the plan had the first qualifying event not occurred. Qualified beneficiaries must notify the Group within sixty (60) days after a second qualifying event to extend the COBRA continuation coverage.

The eighteen (18) months of continuation coverage may also be extended to a maximum of twenty-nine (29) months if a qualified beneficiary is determined to be disabled (as determined under Title II, or XVI of the Social Security Act) by the Social Security Administration before the first day of COBRA coverage, or is declared disabled during the first sixty (60) days of COBRA coverage.

This eleven (11) month extension is available to all eligible individuals who are qualified beneficiaries and elected COBRA continuation coverage for the original eighteen (18) months. The qualified beneficiary must notify the Group of the disability determination before the end of the initial eighteen (18) month COBRA period and within sixty (60) days from:

- the date of the notice from the Social Security Administration of the determination of disability; or

- the date of the qualifying event.

The qualified beneficiary must also notify the Group within thirty (30) days of any final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. In this case, coverage will end the earliest of twenty-nine (29) months after the date of the qualifying event or the first day of the month that begins more than thirty (30) days after a final determination that the qualified beneficiary is no longer disabled, subject to the original eighteen (18) months of COBRA coverage.

Keep Your Plan Informed of Address Changes

In order to protect You and Your family's rights, You should keep the Group informed of any changes in Your address and the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Group Plan Administrator.

### C. Employee Rights Under the Uniformed Services Employment and Reemployment Rights Act (USERRA

Employees going on a military leave of absence to perform "service in the United States uniformed services" (as that term is defined under USERRA) may elect to continue coverage under this Benefit Plan for up to 24 months from the date that the employee leaves for service. Only a covered employee may elect continuation coverage under USERRA for himself/herself and for those eligible Dependents that were covered under the Plan immediately before him/her leaving for military service. Dependents do not have any independent right to elect USERRA continuation coverage.

To claim USERRA continuation coverage, the employee must properly notify the employer that he/she is leaving to perform "service in the uniformed services" and apply for continuation coverage as required by the employer.

An employee who elects USERRA continuation coverage may be required to pay a premium. If the leave of absence lasts thirty (30) days or less, the person may be required to pay the employee's required contribution for coverage. However, if the military leave of absence lasts more than thirty (30) days, the person may be required to pay up to 102% of the full contribution under the Plan (including both, the employer's and the employee's contribution for coverage).

USERRA continuation coverage may be terminated before the maximum 24 month period if:

1. The employee fails to pay the required premiums timely, or

2. The day after the date on which the employee is required under the law to apply for or return to a position of employment and fails to do so.

Employers subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may choose to provide USERRA continuation coverage rights concurrently with COBRA continuation coverage, as allowed by law. Each employer acts independently in choosing how to apply this provision and is not reflective of any guidelines issued from BCBSLA. In all cases, the employer should be consulted on how this provision applies to their employer group sponsored plan.

Please contact your employer to ask for more details on how USERRA and other continuation coverage rights apply to You.

## ARTICLE X. GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS

### A. The Benefit Plan

1. This Benefit Plan, including the application for Group vision coverage, the Schedule of Vision Benefits, and any attached amendments or endorsements, constitute the entire contract between the parties. To the extent that this Benefit Plan may not comply with any federal or state law enacted after its drafting, provisions necessary for such compliance shall be deemed incorporated and the Benefit Plan shall be administered accordingly.

2. Except as specifically provided herein, this Benefit Plan will not make the Company liable or responsible for any duty or obligation imposed on the employer by federal or state law or regulations. To the extent that this Benefit Plan may be an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, the Group will be the administrator of such employee welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the plan, except those specifically undertaken by the Company herein. To the extent this Benefit Plan is subject to COBRA, the Group,

or its contracted designee, will be the administrator for the purposes of COBRA. The Group is responsible for establishing and following all required COBRA procedures that may be applicable to the Group. The Group will indemnify and hold the Company harmless in the event the Company incurs any liability as a result of the Group's failure to do so.

3. The Company will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Provider or his agent or employee or other person participating in or having to do with the care or treatment of a Member.

4. The Company will have full discretionary authority to determine eligibility for Benefits and/or construe the terms of this Benefit Plan.

5. The Company shall have the right to enter into any contractual agreements with subcontractors, Providers or other third parties relative to this Benefit Plan. Any of the functions to be performed by the Company 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 does 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 the Section 1557 Coordinator, who has been designated to coordinate the efforts of Blue Cross Blue Shield of Louisiana to comply with Section 1557 at the following address:

Section 1557 Coordinator
P. O. Box 98012
Baton Rouge, LA 70898-9012
225-298-7238
800-711-5519 (TTY 711)
Fax: 225-298-7240
Email: Section1557Coordinator@bcbsla.com

If You believe You have been subjected to discrimination on the basis of race, color, national origin, sex, age or disability, You may file a grievance under this procedure. It is against the law for Blue Cross Blue Shield of Louisiana to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

- 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

The Company reserves the right to modify the terms of this Benefit Plan upon not less than thirty (30) day notice to the Group. No change or waiver of any Benefit Plan provision will be effective until approved by the Company's chief executive officer or other person authorized to make changes.

## D. Identification Cards and Benefit Plans

We will prepare an identification card for each Subscriber. We will issue a Benefit Plan to the Group and print a sufficient number of copies of the Benefit Plan for Group's Subscribers. At the direction of Group, We will either deliver all materials to the Group for Group'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 Group and Us, the Group has the sole responsibility for distributing all such documents to Subscribers.

## E. Payment of Premiums

1. Our premiums for the Benefit Plan may increase after the Group'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, the Company will give forty-five (45) days written notice to the Group at the last address shown in the Company's regarding any change in rates. Such increase in premiums will become effective on the date specified in the notice and continued payment of premiums will constitute acceptance of the change.

   We reserve the right to increase the premiums more often than stated above due to the Group's addition of a newly covered person or entity not previously considered in the rate determination process at any time during the life of the Benefit Plan. Additionally, the Company reserves 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 Group; or (3) any change in the Benefit level from that which was in force at the time of the last rate determination. Such increase of premiums will become effective on the next billing date following the effective date of the change. Continued payment of premiums will constitute acceptance of the change.

2. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. The Group is considered delinquent if premiums are not paid as of the due date.

3. If the Group does not make payment to the Company home office within thirty (30) days of the due date, this Benefit Plan will be cancelled 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.

**F. Benefits to Which Members are Entitled**

1. The liability of the Company is limited to the Benefits specified in this Benefit Plan.

2. Benefits for Covered Services specified in this Benefit Plan will be provided only for services and supplies rendered on and after the Member's Effective Date by a Provider specified in this Benefit Plan and regularly included in such Provider's charges.

**G. Notice of Member Eligibility - Group's Personnel Data**

1. The Group is solely responsible for furnishing the information that is required by the Company for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate the Company to provide Benefits under this Benefit Plan.

2. All notification of membership or coverage changes must be on forms approved by the Company and include all information required by the Company to effect changes.

3. The Group must notify the Company's Membership & Billing Department of a Member's termination of coverage by completing a cancellation form (or such other form of notification acceptable to Us) and submitting it to Our offices no later than within the next billing cycle immediately following the billing cycle in which the Member or any of the Member's Dependents is terminated from the Group or eligibility for coverage ends (or any other period described in the Schedule of Vision Benefits). The Group will also submit to the Company's Membership & Billing Department evidence of a Member's or his Dependent's election of any applicable COBRA coverage following such termination within three (3) business days of Group's receipt of signed COBRA forms. Company is under no obligation to refund any premium paid by Group or any Member, if payment was made to Company due to Group's failure to timely notify Company of a Member's or his Dependent's termination of coverage.

4. Requests for termination of coverage that are submitted after the period provided above will only be honored prospectively after the date of receipt and the Group 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 Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group 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 Group 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 Group 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 Group warrants the accuracy of the information it transmits to the Company and understands that the Company will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by the Company.

6. The Group further agrees to indemnify the Company for all expenses the Company incurs, if any, as a result of the Group's failure to transmit the information, failure to transmit it in the time period required by the Company, and/or failure to transmit correct information. 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 Group responsible for all premium payments for Members who are not timely cancelled from coverage due to the Group's failure to timely notify the Company of terminations or changes in eligibility.

## H. Termination of a Member's Coverage

1. A Member's coverage may be terminated for fraud at any time. A Member's coverage may be terminated within three (3) years of the Member's Effective Date if material misrepresentation was made in connection with enrollment for coverage.

2. Unless COBRA Continuation of Coverage is available and selected as provided in this Benefit Plan, a Member's coverage terminates as provided below:

   a. The Subscriber's coverage and that of all his Dependents automatically, and without notice, terminates at the end of the period in which the Subscriber ceases to be eligible.

   b. The coverage of the Subscriber's Spouse will terminate automatically, and without notice, at the end of the period for which premiums have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.

   c. The coverage of a Dependent will terminate automatically, and without notice, at the end of the month the Dependent ceases to be an eligible Dependent, if premiums have been paid through that month.

   d. Upon the death of a Subscriber, the coverage of all of his surviving Dependents will terminate automatically and without notice at the end of the month that death occurred if premiums have been paid through that month. However, a surviving Spouse or Dependent may be able to elect COBRA continuation of coverage as described elsewhere in this Benefit Plan.

3. In the event the Group cancels this Benefit Plan or We terminate this Benefit Plan for nonpayment of the appropriate payment when due or because the Group fails to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to end all rights of the Member to Benefits under this Benefit Plan as of the effective date of such cancellation or termination. The Group shall have the obligation to notify its Members, participants, and beneficiaries of such cancellation or termination. We shall have no such obligation of notification at the Member level.

4. Except as otherwise provided in this Benefit Plan, no Benefits are available to a Member for Covered Services rendered after the date of cancellation or termination of a Member's coverage.

5. The Company reserves the right to automatically change the Subscriber's class of coverage to reflect when no more children or grandchildren are covered under this Benefit Plan.

## I. Filing of Claims

Members and /or Providers must file all Claims in a form acceptable to Davis Vision 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.

## J. 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 file.

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.

## K. Release of Information

We may request that the Member or the Provider furnish certain information relating to the Member's Claim for Benefits. We will hold such information, records, or copies of records as confidential except where in the Company's discretion the same should be disclosed.

## L. Member/Provider Relationship

1. The choice of a Provider within the Davis Vision Network is solely the Member's.

2. The Company and all vision network Providers are to each other independent contractors, and will not be considered to be agents, representatives, or employees of each other for any purpose whatsoever. Blue Cross and Blue Shield of Louisiana does not render Covered Services, but only makes payment for Covered Services that the Member receives. The Company will not be held liable for any act or omission of any Provider, or any Claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any vision network Provider or in any vision network Provider's facilities. The Company has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.

3. The use or non-use of an adjective such as Participating and Non-Participating in referring to any Provider is not a statement as to the ability of the Provider.

## M. Applicable Law

This Benefit Plan will be governed and construed in accordance with the laws and regulations of the State of Louisiana, except when preempted by federal law. This Benefit Plan is not subject to regulations by any state other than the State of Louisiana.

If any provision of this Benefit Plan is in conflict with any applicable statutes of the State of Louisiana, the provision is automatically amended to meet the minimum requirements of the statute. 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 Group will be sent to the Group's address stated in the application for Group coverage. Notice given to the Company will be sent to the Company's address stated in the application for Group coverage.

Any notice required to be given will be considered delivered when deposited in the United States Mail, postage prepaid, addressed to the Member at his address as the same appears on the records of the Company, or to the Group at the address as the same appears on the records of the Company. The Group, the Company, or a Member, by written notice, may indicate a new address for giving notice.

## O. Job-Related Injury or Illness

The Group must report to the appropriate governmental agency any job-related injury or illness of a Subscriber where so required under the provisions of any legislation of any governmental unit. This Benefit Plan, with certain described exceptions, excludes Benefits for any services covered in whole or in part by Workers' Compensation laws and/or rendered as a result of occupational disease or injury, subject to the provisions of L.R.S. 23:1205 (C). In the event Benefits are initially extended by the Company and a

compensation carrier or employer makes any type of settlement with the Subscriber, with any person entitled to receive settlement where the Subscriber dies, or if the Subscriber's injury or illness is found to be compensable under law, the Group or Subscriber must reimburse the Company for Benefits extended or direct the compensation carrier to make such reimbursement. The Company will be entitled to such reimbursement even if the settlement does not mention or excludes payment for vision Benefits expenses.

**P. Subrogation**

1. To the extent that Benefits for Covered Services are provided or paid under this Benefit Plan, the Company will be subrogated and will succeed to the right of the Member for the recovery of the amount paid under this Benefit Plan against any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured. The acceptance of such Benefits hereunder will constitute such subrogation. Our right to recover shall be subordinate to the Member's right to be "made whole." The Company will be responsible for its proportionate share of the reasonable attorney fees and costs actually incurred by the Member in pursuing recovery.

2. The Member will reimburse the Company all amounts recovered by suit, settlement, or otherwise from any person, organization or other carrier, even where such carrier provides Benefits directly to a Member who is its insured, to the extent of the Benefits provided or paid under this Benefit Plan. The Company's right to reimbursement shall be subordinate to the Member's right to be "made whole." The Company agrees that it will be responsible for its proportionate share of the reasonable attorney fees and costs actually paid by a Member in pursuing recovery.

3. The Member will take such action, furnish such information and assistance, and execute such papers as the Company may be required to facilitate enforcement of its rights, and will take no action prejudicing the rights and interest of the Company under this Benefit Plan. Nothing contained in this provision will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Benefit Plan.

4. The Member is required to notify the Company of any Accidental Injury.

**Q. Right of Recovery**

When payment for Covered Services has been made by the Company in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or when payment exceeds the Allowable Charge or has been made in error by the Company or for non-Covered Services, the Company will have the right to recover such payment from the Member or, if applicable, the Provider.

As an alternative, the Company reserves the right to deduct from any pending Claim for payment under this Benefit Plan any amounts the Member or Provider owes the Company.

**R. Coverage in a Department of Veterans Affairs or Military Hospital**

In any case in which a veteran is furnished care or services by the Department of Veterans Affairs for a non-service-connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from the Company to the extent the veteran would be eligible for Benefits from the Company if the care or services had not been furnished by a department or agency of the United States.

The amount the United States may recover will be reduced by the appropriate deductible and coinsurance or copayment amount. The United States will have the right to collect from the Company the reasonable cost of 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 the Company if the retiree or Dependent were to incur such cost on his or her own behalf. The amount the United States may recover will be reduced by the appropriate deductible, coinsurance and copayment amount.

## S. Liability of Plan Affiliates

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Plan constitutes a contract solely between the Group and Blue Cross and Blue Shield of Louisiana, that Blue Cross and Blue Shield of Louisiana is 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 Blue Cross and Blue Shield of Louisiana to use the Blue Cross and Blue Shield Service Marks in the State of Louisiana), and that Blue Cross and Blue Shield of Louisiana is not contracting as the agent of the Association. The Group on behalf of itself and its participants further acknowledges and agrees that it has not entered into this Benefit Plan based upon representations by any person other than Blue Cross and Blue Shield of Louisiana and that no person, entity, or organization other than Blue Cross and Blue Shield of Louisiana shall be held accountable or liable to the Group for any of Blue Cross and Blue Shield of Louisiana's obligations to the Group created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Louisiana other than those obligations created under other provisions of this agreement.

## T. Continued Coverage During a Leave of Absence

As stated in the Schedule of Eligibility, an employee must be actively working for his employer/Group to be entitled to coverage under this Benefit Plan. Each of the following provisions are exceptions to the requirement that the employee be actively working in order for coverage to apply. The following provisions are independent of each other and only one need apply for Subscriber and his Dependents to be entitled to continued coverage under this Plan.

1. Company will continue coverage for Subscriber during any leave of absence the Group is required to provide by applicable federal or state law, including the Family and Medical Leave Act of 1993 (FMLA) and any amendments or successor provisions, as long as all other eligibility criteria under the law continues to be met. If Subscriber's coverage is terminated during a leave under the FMLA, upon return to active full-time employment, Subscriber is entitled to re-enroll for coverage, so long as the Group maintains coverage with Company. If the Subscriber is not restored to active full-time employment by the end of the leave of absence period, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate at the end of the billing period in which the leave of absence period expires, or as otherwise described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.

2. When a Subscriber is not actively at work due to a health condition, Company will maintain coverage for the Subscriber and any Dependents, as long as the Subscriber remains a bona fide employee of the Group and premiums are paid. If Group terminates Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.

3. When a Subscriber has been granted a documented, approved leave of absence by the employer Group, and the leave of absence is not due to Subscriber's health, Company will maintain coverage for the Subscriber and any Covered Dependents for a period not to exceed ninety (90) days. Premiums must be paid and Subscriber must remain a bona fide employee of Group during the approved leave period. Group will provide Company with proof of the documented leave, upon request. If Group terminates Subscriber's employment, the Subscriber will cease to be eligible and coverage for the Subscriber and any Dependents will terminate as described in "Termination of a Member's Coverage." Subscriber and Dependents may have the right to continue coverage thereafter under the Continuation of Coverage Rights article of this Benefit Plan.

## ARTICLE XI. 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, Davis Vision or one of Our Providers. If a Member wants to register a Complaint or file a formal written Grievance about Us, Davis Vision or a Provider, please refer to the procedures below.*

*A Member may be dissatisfied about decisions made regarding Covered Services. Davis Vision considers the Member's request to change Our coverage decision as an Appeal. We define an Appeal as a written request from a Member or authorized representative to change a previous decision made by Us about covered services. Your Appeal rights are outlined below, after the Complaint and Grievance procedures.*

There is an Expedited Appeals process for situations where the time frame of the standard Medical Necessity Appeal 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 and Grievance Procedures

A quality of service concern addresses Our services, access, availability or attitude and those of Our Network Providers. A quality of care concern addresses the appropriateness of care given to a Member.

1. To Register a Complaint

   A Complaint is an oral expression of dissatisfaction with Us, Davis Vision or with Provider services. Members may call Our Customer Service Department at 1-800-247-9368 to register a Complaint. We will attempt to resolve the Member's Complaint at the time of his call.

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 his Complaint was adequately resolved or he wishes to file a formal Grievance, a written request must be submitted within one hundred eighty (180) days. Davis Vision customer service department will assist the Member if necessary.

   The Member should send his written Grievance to:

   Davis Vision
   Quality Assurance Department
   P. O. Box 791
   Latham, NY 12110

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

### 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.

Davis Vision offers two (2) levels of Appeal for both administrative Appeals and Medical Necessity Appeals.

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 1-800-247-9368 if the Member is unsure whether ERISA is applicable.

The Member may also call Davis Vision if they have questions or need assistance putting their Appeal in writing. Providers will be notified of Appeal results only if the Provider filed the Appeal.

## C. Standard Appeal Process

Davis Vision will determine if a Member's Appeal as either an administrative Appeal or a Medical Appeal. The Member is encouraged to provide Davis Vision with all available information to help completely evaluate the Appeal such as written comments, documents, records, and other information relating to the Adverse Determination. We will provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his Adverse Determination.

The Member has the right to appoint an authorized representative to represent him in his Appeals. An authorized representative is a person to whom the Member has given written consent to represent him in a review of an Adverse Benefit Determination. The authorized representative may be the Member's treating Provider, if the Member appoints the Provider in writing.

All Appeals including administrative Appeals and Medical Necessity Appeals should be submitted in writing to:

Davis Vision
Quality Assurance Department
P. O. Box 791
Latham, NY 12110

1. Administrative Appeals

   Administrative Appeals involve contractual issues other than Medical Necessity such as an Adverse Benefit Determinations based on limitations or exclusions.

   a. First Level Administrative Appeals

      If a Member is not satisfied with the original decision, a written request to Appeal must be submitted within one hundred eighty (180) days of receipt of the initial Adverse Benefit Determination for first level administrative Appeals. Requests submitted to Davis Vision after one hundred eighty (180) days of the initial Adverse Benefit Determination will not be considered.

      Davis Vision will investigate the Member's concerns. If the administrative Appeal is overturned, Davis Vision will reprocess the Member's Claim, if any. If the administrative Appeal is upheld, Davis Vision will inform the Member of the right to begin the second level administrative 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 the first level administrative Appeal decision. Requests submitted to Davis Vision after sixty (60) days of the first level administrative 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 administrative 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 thirty (30) days of the Committee meeting.

2. Medical Necessity Appeals

Medical Necessity Appeals involve a denial or partial denial based on Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or Investigational.

a. First Level Internal Medical Necessity Appeals

If a Member is not satisfied with the original decision, a written request to Appeal must be submitted within one hundred eighty (180) days of the initial Adverse Benefit Determination for first level Medical Necessity Appeals. Requests submitted to Davis Vision after one hundred eighty (180) days of the initial Adverse Benefit Determination will not be considered.

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

The Medical Necessity 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 Medical Necessity Appeals

If a Member still disagrees with the first level Medical Necessity Appeal decision, a written request to Appeal must be submitted within sixty (60) days of the first level Medical Necessity Appeal decision. Requests submitted to Davis Vision after sixty (60) days of the first level Medical Necessity Appeal decision will not be considered.

The second level Medical Necessity Appeal will be reviewed by a Provider who holds a non-restricted license issued in the United States in the same or an appropriate specialty that typically manages the condition, procedure or treatment under review. The decision is final and binding.

The 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 the review.

**D. Expedited Medical Necessity Appeal**

*An Expedited Appeal process is available to review a Medical Necessity Appeal involving an urgent care claim. An urgent care claim is a claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant to regain maximum function, or, in the opinion of a Provider with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject to the claim.*

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, mail to:

Davis Vision
Quality Assurance Department
P. O. Box 791
Latham, NY 12110

Davis Vision will make a decision no later than seventy-two (72) hours of receipt of an Expedited Appeal.

*You may contact the Commissioner of Insurance directly for assistance with any Appeal issues at the following address and phone numbers:*

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

## ARTICLE XII. ERISA RIGHTS

To the extent this is an ERISA plan, the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For purposes of this provision, the Group is considered the Plan Administrator and will be subject to the provisions stated below. ERISA provides that all Plan Participants (Members) shall be entitled to:

### A. Receive Information About the Plan and Benefits

1. A Member may examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the United States Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Upon written request to the plan administrator, a Member may obtain copies of documents governing the operation of the plan, including any applicable insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

3. A Member may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

### B. Continue Group Vision Coverage

A Subscriber may continue Vision Benefits coverage for himself, his Spouse, or his Dependents, if there is a loss of coverage under the plan as a result of a qualifying event. The Subscriber or Dependents may, however, have to pay for such coverage. A Member may also review this document and the summary plan description governing the plan on the rules pertaining to the Member's COBRA continuation of coverage rights.

### C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Subscriber and other beneficiaries. No one, including his employer, union or any other person, may fire him or otherwise discriminate against him in any way to prevent him from obtaining a plan benefit or exercising his rights under ERISA.

### D. Enforce Member's Rights

1. If a Member's Claim for a plan Benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps the Member can take to enforce the above rights. A Member must exhaust all Claims and Appeal procedures available to him before filing any suit. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the Member may file suit in Federal Court. In such a case, the

court may require the plan administrator to provide the materials and pay the Member up to one hundred and ten dollars ($110.00) a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If the Member has a Claim for Benefits, which is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if he disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, such Member may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his rights, he may seek assistance from the United States Department of Labor, or he may file suit in a Federal Court.

3. The court will decide who should pay court costs and legal fees. If the Member is successful, the court may order the person he has sued to pay these costs and fees. If the Member loses, the court may order him to pay these costs and fees, for example, if it determines that his claim is frivolous.

### E. Assistance With Member Questions

If a Member has any questions about his plan, he should contact the plan administrator. If a Member has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the plan administrator, he should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

The Member may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## ARTICLE XIII. MAKING PLAN CHANGES AND FILING CLAIMS

All of the forms mentioned in this section can be obtained from the Employer's personnel office or Our home office. If the Member needs to submit documentation to Us, the Member may forward it to Our home office at:

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 98029-9029
or to Our street address, 5525 Reitz Avenue, Baton Rouge, LA 70809.

If the Member has any questions about any of the information in this section, the Member may speak to their Employer or call the customer service department at the number shown on his ID card.

### CHANGING FAMILY MEMBERS ON THE MEMBER'S PLAN

The Schedule of Eligibility lets the Member know when it is necessary for the Member to apply for coverage to enroll additional family members to the Member's plan. The Member should read the Schedule of Eligibility and this section as they contain important information.

The Employee Enrollment / Change Form is the document that We must receive in order to enroll family members not listed on the Member's original application/enrollment form. The Schedule of Eligibility will tell the Member whether We require the Employee Enrollment / Change Form and/or the health questionnaire. Because the Member is covered under a Group insurance contract, it is extremely important that the Member follow the timing rules in the Schedule of Eligibility for making these changes to the Member's policy. If the Member does not complete and return a required Employee Enrollment / Change Form to Us so We receive it within the timeframes set out in the Schedule of Eligibility, it is possible that the Member's insurance coverage will not be expanded to include the additional family members. Completing and returning a Employee Enrollment / Change Form is especially important when the Member's first Dependent becomes eligible for coverage or when the Member no longer has any eligible Dependents.

If the Member has any changes in their family, the Member must file a Employee Enrollment / Change Form. The Member may also be asked to complete the health questions for these family members. The Schedule of Eligibility explains when coverage becomes effective for new family members. Generally, a Employee Enrollment / Change Form is used to add newborn children, newborn adopted children, a Spouse, or other Dependents not listed on the Member's original application for coverage. We should receive the Member's completed form in Our home office within thirty (30) days of the child's birth or placement, or the Member's marriage.

## FILING INSURANCE CLAIMS FOR BENEFITS

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

Davis Vision
P.O. Box 1525
Latham, NY 12110

The Member's Blue Cross and Blue Shield Identification Card (ID card) shows the way the name of the Subscriber (Member of the Group) appears on the Company records. (If the Member has Dependent coverage, the name(s) are recorded as the Member wrote them on the enrollment form.)

The ID card also lists the Member's Identification number (ID #). This number is the identification to the Member's membership records and should be provided to Davis Vision each time a Claim is filed.

If the Subscriber completes the Claim form and this is a Group plan, remember: the Subscriber is the employee Member (if this is a group contract). If the Subscriber is the patient, the relationship is SELF. If the Subscriber's wife or husband is the patient, the relationship is SPOUSE.

To assist in promptly handling the Member's Claims, the Member must be sure that:

a. an appropriate Vision Claim form is used

b. Member Identification (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, whether on the Claim form or on the attached statement

f. the date of service or date of treatment is correct

g. the Claim is completed and signed by the Member and the Provider.

IMPORTANT NOTE: The Member must be sure to check all Claims for accuracy. This Member Identification number (ID #) must be correct. It is important that the Member keep a copy of all bills and Claims submitted. If Blue Cross and Blue Shield of Louisiana is a secondary payor, the Member may be required to submit his Explanation of Benefits from his primary payor.

## IF A MEMBER HAS A QUESTION ABOUT HIS CLAIM

If a Member has a question about the processing or payment of a Claim, the Member can write Davis Vision at the below address or the Member may call Davis Vision at 1-800-247-9368. If the Member calls for information about a Claim, Davis Vision can help the Member better if the Member has the information at hand--particularly this Member Identification number, patient's name and date of service.

Davis Vision
P.O. Box 1525
Latham, NY 12110

Remember, the Member must ALWAYS refer to his Member Identification number in all correspondence.

## ARTICLE II. GENERAL PROVISIONS – GROUP/POLICYHOLDER ONLY

**IN ADDITION TO THE GENERAL PROVISIONS FOR GROUP/POLICYHOLDER AND MEMBERS, THE FOLLOWING GENERAL PROVISIONS WILL ALSO APPLY TO THE GROUP/POLICYHOLDER.**

### A. Due Date for Group's Premium Payments

1. Premiums are due and payable from Group/Policyholder in advance, prior to coverage being rendered. Premiums are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. This is the premium due date.

2. Premiums are owed by Group/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. If a premium is not paid when due, We may agree to accept a late premium. We are not required to accept a late premium. The fact that We may have previously accepted a late premium does not mean we will accept late premiums in the future. You may not rely on the fact that We may have previously accepted a late premium as indication that We will do so in the future.

4. Premiums must be paid in US dollars. Policyholder will be assessed a twenty-five dollar ($25.00) NSF fee should its premium be paid with a check that is returned by the bank due to insufficient funds. If multiple payments are returned by the bank, Company may at its sole discretion refuse to reinstate coverage.

### B. Change in Premium Amount

1. Premiums for this Benefit Plan may increase after the Group'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 Group forty-five (45) days written notice of any change in premium rates. We will send notice to the Group's latest address shown in Our records. Any increase in premium is effective on the date specified in the rate change notice. Continued payment of premium will constitute acceptance of the change.

2. We reserve the right to increase the premiums more often than stated above due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the Benefit Plan. This risk includes, but is not limited to, the right to increase the premium amount because of: (1) the addition of a newly covered person; (2) the addition of a newly covered entity; (3) a change in age or geographic location of any individual insured or policyholder; (4) or a change in the policy Benefit level from that which was in force at the time of the last rate determination. An increase in premium will become effective on the next billing

date following the effective date of the change to the risk. Continued payment of premium will constitute acceptance of the change.

**C. Group's Right to Cancel the Policy**

1. This policy is guaranteed renewable at the option of the Group. Group indicates its desire to continue coverage by its timely payment of each premium as it becomes due.

2. Group may cancel this policy for any reason.

3. To cancel the policy, Group must give Company WRITTEN NOTICE of its intent to cancel. GROUP MAY NOT VERBALLY CANCEL THIS COVERAGE. GROUP'S WRITTEN NOTICE OF CANCELLATION MUST BE GIVEN TO COMPANY PRIOR TO OR ON THE EFFECTIVE DATE OF THE CANCELLATION AND MUST BE ACCOMPANIED BY RETURN OF THE INSURANCE POLICY. If Group's written notice to Company of its intent to cancel is not accompanied by the surrendered policy, Group's cancellation notice to Company shall be deemed to include Group's declaration that the Group made a good faith attempt to locate its policy and the policy is not returned because it has been lost or destroyed.

**D. Company's Right to Terminate the Policy for Nonpayment of Premium**

1. Premiums are to be prepaid before coverage is rendered. The Group is considered delinquent if premiums are not paid on the due date.

2. The Company offers a thirty (30) day grace period (delinquency period) from the due date of the premium. If We receive the premium during the grace period, coverage remains in effect during the grace period pursuant to the provisions of the policy. If We do not receive the premium during the grace period, We will mail a delinquency/termination notice to the Group's address of record. We may automatically terminate the policy without further notice to the Group if we do not receive Group's premium at Our home office within thirty (30) days of the due date (during the grace period). If We terminate this Benefit Plan for nonpayment of premium, termination will be effective midnight of the last day for which premiums have been paid.

   The Company will not be liable for any Benefits for services rendered following the last date through which premiums have been paid.

**E. Company's Right to Terminate the Policy for Reasons Other Than Nonpayment of Premium**

1. Company may terminate this Benefit Plan if any one of the following occurs:

   a. Group commits fraud or makes an intentional misrepresentation.

   b. Group fails to comply with a material plan provision, including, but not limited to provisions relating to eligibility, employer contributions or group participation rules. If the sole reason for termination is that Group's participation falls to less than two (2) employees (there is only one (1) employee covered (or owner, if covered)), termination of Group coverage will be effective on the Group's next anniversary date. Otherwise, termination for a reason addressed in this paragraph will be effective after Group receives sixty (60) days written notice as described below.

   c. In the case of network plans, there is no longer any enrollee under the Group benefit plan that lives, resides, or works in the service area of the Company or in the area for which the Company is authorized to do business.

   d. Company ceases to offer this product or coverage in the market.

2. If Company terminates this coverage because of prongs "a", "b", or "c", We will give Group written notice at least sixty (60) days in advance. Company will give notice by certified mail and shall

include the reason for termination. Notice of termination because of prong "e" will be sent to the Group by regular mail ninety (90) days in advance of termination.

**F. Proxy Votes**

Election of Our Board of Directors and certain significant corporate transactions are determined by a majority vote of Our policyholders, unless a different vote is required by law or Our Articles of Incorporation or Bylaws. A policyholder designates, by means of the application for coverage, the members of Our Board of Directors 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 Us at P.O. Box 98029, Baton Rouge, Louisiana 70898-9029. In lieu of giving his proxy in 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 policy number, sent to Us as indicated above. Notice of meetings to the proxy constitutes notice to the policyholders giving their proxies. Further, notice is hereby given that Our annual meeting 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.

**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 Group

   a. Sharing Summary Health Information With the Group:

      The Company may disclose Summary Health Information to the Group if the Group 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 Group:

      The Company may disclose PHI to the Group to enable the Group to carry out plan administration functions only upon receipt of a certification from the Group 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

      (3) that such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other Benefits or employee benefits plan of the Group.

   c. The Group hereby agrees to abide by the Company's acknowledgement and authorization policies with regards to the exchange of PHI in an electronic format. For example, if the Company provides data to the Group on a compact disc, the Company may require acknowledgement that the data was received by the Group and the name of the Group representative who received the data.

## H. United States Economic Sanctions Laws Compliance

The Group 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 Group understands that Blue Cross and Blue Shield of Louisiana does not authorize extending coverage to any person to whom the provision of such coverage would be receiving insurance coverage under this or other Blue Cross and Blue Shield of Louisiana Policies, including Subscribers and their covered Dependents, against all relevant United States Government lists of persons subject to trade, export, financial, or transactional sanctions, including the most current version of OFAC's list of Specially Designated Nationals and Blocked Persons, before providing or agreeing to provide coverage to any person.

The Group 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 Group 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.

**LLHIGA NOTICE**

**SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS**

A. Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association, or LLHIGA. The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**DISCLAIMER**

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage. Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer. The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

**LLHIGA**
P.O. Drawer 44126
Baton Rouge, Louisiana 70804

**Department of Insurance**
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

B. The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S.22:2081 et seq. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

C. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well, even if they live in another state; unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

D. Exclusion from Coverage

1. A person who holds a direct non-group life, health, health maintenance organization, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

   a. he is eligible for protection under the laws of another state;

   b. the insurer was not authorized to do business in this state;

   c. his policy was issued by a profit or nonprofit hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined by law, or any entity similar to any of these.

2. LLHIGA also does not provide coverage for:

    a. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

    b. any policy of reinsurance (unless an assumption certificate was issued);

    c. interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;

    d. dividends, premium refunds, or similar fees or allowances described under the law;

    e. credits given in connection with the administration of a policy by a group contract holder;

    f. employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;

    g. unallocated annuity contracts (which give rights to group contract holders, not individuals), except if qualified by law

    h. an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;

    i. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A coverage", "Medicare Part B coverage", "Medicare Part C coverage", or "Medicare Part D coverage" and any regulations issued pursuant to those parts;

    j. interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

E. Limits on Amounts of Coverage

1. The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.

2. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

    a. LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.

    b. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.

    c. For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

3. In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

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.



Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc., and Southern National Life Insurance Company, Inc., are subsidiaries of Blue Cross and Blue Shield of Louisiana. All three companies are independent licensees of the Blue Cross and Blue Shield Association.

# 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)