



LSU First

Louisiana State University Health Plan

Plan Document and Summary Plan Description

Effective: January 01, 2013

Restated: January 01, 2023

Claims Processed by:



8500 Freeport Parkway, Suite 400
Irving TX 75063
Toll Free: 1-855-346-LSU1

Utilization Management:
Communitas

Care Coordination:
HighCare Health Care Coordination

Pharmacy Benefit Manager:
MedImpact

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ESTABLISHMENT OF THE PLAN:

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (“Plan Document”), made by **Louisiana State University** (the “Plan Sponsor”) as of January 1, 2023, hereby sets forth the provisions of the LSU First Louisiana State University Health Plan (the “Plan”), which was originally adopted by the Plan Sponsor, effective January 1, 2013. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the “Effective Date”).

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Louisiana State University

By: _____

Name: _____

Title: _____

Date: _____

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Illness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Participants in the Plan to the maximum feasible extent.

The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **Louisiana State University** and may be reviewed at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:

LSU First Louisiana State University Health Plan

Plan Sponsor:

**Board of Supervisors of Louisiana State University and Agricultural and Mechanical College
3810 W. Lakeshore Drive
Baton Rouge, Louisiana 70808
Phone: 1-225-578-4904**

Plan Administrator:

(Named Fiduciary)

**Louisiana State University and Agricultural and Mechanical College
110 Thomas Boyd Hall
Baton Rouge, Louisiana 70803
Phone: 1-225-578-8200**

Source of Funding:

Self-Funded

Plan Status:

Non-Grandfathered

Applicable Law:

Federal and State of Louisiana

Plan Year:

January 1 to December 31

Plan Type:
Medical
Prescription

Third Party Administrator:
WebTPA
8/500 Freeport Parkway, Suite 400
Irving, TX 75063
Phone: 1-855-346-LSU1
Email: helpme@webtpa.com

Prescription Drug Plan Administrator:
MedImpact
Phone: 1-833-229-3594
Email: www.medimpact.com

Participant Employer(s):
Louisiana State University
110 Thomas Boyd Hall
Baton Rouge, Louisiana 70803
Phone: 1-225-578-8200
Email: lsufirst@lsu.edu

Agent for Service of Process:
Louisiana State University
Office of General Counsel
3810 West Lakeshore Drive
Baton Rouge, LA 70808

Utilization Review Manager:
WebTPA
1-855-346-LSU1

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Plan Sponsor and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Plan Sponsor with the bargaining representatives of any Employees.

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the plan documents and applicable state law and regulations.

Discretionary Authority

To the extent allowed by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines

In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

1. The 30-day period (or 60-day period, if applicable) to request special enrollment under Internal Revenue Code section 9801(f);
2. The 60-day election period for COBRA continuation coverage under Internal Revenue Code section 4980B(f)(5);
3. The date for making COBRA premium payments pursuant to Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4. The date for individuals to notify the Plan of a qualifying event or determination of disability under Internal Revenue Code section 4980B(f)(6)(C);

In no instance will the duration of an extension granted under this section exceed one calendar year.

Member Advocates

Plan Member Advocates are available to all Plan Members regarding claim related issues. The Member Advocate is not employed by WebTPA, MedImpact or LSU, and you may consult the Member Advocates on a confidential basis. To access the Member Advocates, contact your local Human Resources Department.

Accessing LSU First Plan Information and Your Personal Account Information Online

First, go to www.lsu.edu/lsufirst. This is your entry point for all of your health care needs. From here, you can find Plan-related information, forms, and news, and search for an In-Network Medical or Pharmacy Provider. From www.lsu.edu/lsufirst, you can access both www.webtpa.com and www.medimpact.com.

At www.webtpa.com you can view your medical claims information, complete a health assessment, review account balances, search for Providers, plus much more. To register at www.webtpa.com:

- Go to www.lsu.edu/lsufirst
- Click on the www.webtpa.com link.
- From www.webtpa.com select “Register Now” in the lower left-hand corner.
- Enter the requested personal information.
- Create a username and password to confirm your identity. Call 1-855-346-LSU1 if you have technical questions about logging in. Once you are registered you can:
 - Order a new ID card or print a temporary one
 - Learn about your Plan’s covered benefits in more detail
 - Check your balances, past transactions, and claims status

At www.medimpact.com, you can review your claims history and locate MedImpact network pharmacies. To register at www.medimpact.com:

- Go to www.lsu.edu/lsufirst
- Click on www.medimpact.com
- Select “Member” located on the upper right corner of the page.
- Follow steps to create a unique user name and password.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

“Accident”

“Accident” shall mean an event which takes place without one’s foresight or expectation, or a deliberate act that results in unforeseen consequences.

“Accidental Bodily Injury” or “Accidental Injury”

“Accidental Bodily Injury” or “Accidental Injury” shall mean an Injury sustained as the result of an Accident and due to an outside an outside traumatic event, or due to exposure to the elements.

“Actively At Work” or “Active Employment”

An Employee is “Actively at Work” or in “Active Employment” on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively At Work on each day of a regular paid vacation or on a regular non-working day on which the covered Employee is not totally disabled, provided the covered Employee was Actively At Work on the last preceding regular work day. An Employee shall be deemed Actively At Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan’s Leave of Absence provisions. An Employee will not be considered under any circumstances Actively At Work if he or she has effectively terminated employment.

“ADA”

“ADA” shall mean the American Dental Association.

“Adverse Benefit Determination”

“Adverse Benefit Determination” shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

“Affordable Care Act (ACA)”

The “Affordable Care Act (ACA)” means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

“AHA”

“AHA” shall mean the American Hospital Association.

“Alternate Recipient”

“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”

“Ambulatory Surgical Center” shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

“Approved Clinical Trial”

“Approved Clinical Trial” means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless out-of network benefits are otherwise provided under the Plan.

“Benefits”

“Benefits” shall mean any amounts paid to a Participant in the Plan as reimbursement for Covered Expenses incurred by the Participant and/or covered dependents during a Plan Year.

“Birthing Center”

An inpatient or outpatient facility which:

- Complies with licensing and other legal requirements in the jurisdiction where it is located;
- Is engaged mainly in providing a comprehensive Birth Services program to pregnant individuals who are considered normal low risk patients;
- Has organized facilities for Birth Services on its premises;
- Has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a Certified Nurse Midwife/Certified Professional Midwife (CNM, CPM); and
- Has 24-hour-a-day Registered Nurse Services.

“Calendar Year”

“Calendar Year” shall mean the 12 month period from January 1 through December 31 of each year.

“Cardiac Care Unit”

“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

“CDC”

“CDC” shall mean Centers for Disease Control and Prevention.

“Certified IDR Entity”

“Certified IDR Entity” shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

“Child” and/or “Children”

“Child” and/or “Children” shall mean the Employee’s natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee has been named legal guardian. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee’s physical custody in anticipation of adoption. “Child” shall also mean a covered Employee’s Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993. A “legal guardian” is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

“CHIP”

“CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”

“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”

“Chiropractic Care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claim Determination Period”

“Claim Determination Period” shall mean each Calendar Year.

“Claimant”

“Claimant” shall mean a Participant of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

“Clean Claim”

A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A

defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

“Cleft Lip and Cleft Palate Services”

“Cleft Lip and Cleft Palate Services” shall mean preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

“CMS”

“CMS” shall mean Centers for Medicare and Medicaid Services.

“COBRA”

“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Coinsurance”

“Coinsurance” shall mean a cost sharing feature of many plans, which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

“Congenital Anomaly”

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

“Copayment” or “Copay”

“Copayment” or “Copay” shall mean a dollar amount per visit the Participant pays to the Provider for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

“Cosmetic Surgery”

“Cosmetic Surgery” shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

“Covered Expense(s)”

“Covered Expense(s)” shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant’s health, which is eligible for coverage in

accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums as set forth elsewhere in this document.

“Coverage Tier”

“Coverage Tier” represents the tier you have elected based on Dependents you wish to have covered. Example:

- Employee Only
- Employee plus Spouse
- Employee plus Child(ren)
- Family Coverage

“Custodial Care”

“Custodial Care” shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

“Deductible”

“Deductible” shall mean the aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for themselves each Calendar Year before the Plan will begin its payments.

“Dentist”

“Dentist” shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

“Dependent”

“Dependent” shall mean one or more of the following person(s), so long as they are not also covered as an Employee:

1. Legal spouse of Employee/Retiree. The term "spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The Plan Administrator may require documentation proving a legal marital relationship.
2. A Child from date of birth until the last day of the month in which the Child turns 26 years old; or,
3. Child of Employee/Retiree age 26 or older who is incapable of self-sustaining employment due to mental retardation or physical incapacity who was covered prior to age 26 or a natural or legally adopted Child of Plan Member.

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator. Please see “Dependent Verification Requirements” in the Eligibility Section of this Document.

NOTE: Tax treatment for certain dependents. Federal tax law generally does not recognize former spouses or Legally Separated spouses, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.

“Diagnosis”

“Diagnosis” shall mean the act or process of identifying or determining the nature and cause of a disease or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

“Diagnostic Service”

“Diagnostic Service” shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

“Drug”

“Drug” shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: “Caution—Federal Law prohibits dispensing without prescription,” or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. “Drug” shall also mean insulin for purposes of injection.

“Durable Medical Equipment”

“Durable Medical Equipment” shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all of the following requirements:

1. Can withstand repeated use.
2. Is primarily and customarily used to serve a medical purpose.
3. Generally is not useful to a person in the absence of an Illness or Injury.
4. Is appropriate for use in the home.

“Emergency”

“Emergency” shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”

“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Services”

“Emergency Services” shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

“Employee”

A full-time Employee of an Employer or Participant Employer (“full-time Employee” means a person employed at 75% effort or greater per pay period (average 30 hours per week), with an appointment of more than 120 days or one academic semester). In all cases, eligibility determinations shall be made in accordance with the applicable statutory and regulatory provisions of the Office of Group Benefits. As used in this SPD, the term “Employee” includes a “Retiree”, as defined herein, unless the context clearly indicates otherwise.

“Employer”

“Employer” is Board of Supervisors of Louisiana State University and Agricultural and Mechanical College or any agency or subdivision of the State of Louisiana whose eligibility for coverage under the Plan is established by written agreement or Memorandum of Understanding between Louisiana State University and Agricultural and Mechanical College and the State of Louisiana, Office of the Governor, Division of Administration, Office of Group Benefits.

“Essential Health Benefits”

“Essential Health Benefits” shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

“Exclusion”

“Exclusion” shall mean conditions or services that this Plan does not cover.

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA’s Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:
 - a. Maximum tolerated dose.
 - b. Toxicity.
 - c. Safety.
 - d. Efficacy.
 - e. Efficacy as compared with the standard means of treatment or Diagnosis.

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:
 - a. Maximum tolerated dose.
 - b. Toxicity.
 - c. Safety.
 - d. Efficacy.
 - e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the Food and Drug Administration (FDA) but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug, provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. A clinical study or review article in a reviewed professional journal.

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Explanation of Benefits (EOB)”

“Explanation of Benefits” shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

“Family Unit”

“Family Unit” shall mean the Employee and his or her Dependents covered under the Plan.

“FDA”

“FDA” shall mean Food and Drug Administration.

“Final Internal Adverse Benefit Determination”

“Final Internal Adverse Benefit Determination” shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

“FMLA”

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”

“FMLA Leave” shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Plan Sponsor is required to extend to an eligible Employee under the provisions of the FMLA.

“GINA”

“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“Habilitation/Habilitative Services”

“Habilitation/Habilitative Services” are therapeutic services that are provided to people with congenital or genetic condition(s), that are present from birth, to enhance the person’s ability to function. Habilitative services are similar to rehabilitative services that are provided to adults or children who acquire a condition later on. The difference is that rehabilitative services are geared toward reacquiring a skill that has been lost or impaired, while habilitative services are provided to help acquire a skill in the first place, such as walking or talking. Habilitative services include, but are not limited to, physical therapy, occupational therapy and speech therapy for the treatment of a person with a congenital or genetic birth defect.

“Health Reimbursement Account (HRA)”

“Health Reimbursement Account (HRA)” shall mean the account established by the Plan to fund a portion of the Deductible, based on the coverage tier and Plan Option selected. A HRA balance that is not applied to reimbursement of Eligible Health Expenses in any Plan Year shall be carried forward into the next Plan Year, up to a maximum of 1 time current year HRA, and may accumulate in a Participant’s Health Reimbursement Account throughout a Participant’s Period of Coverage

“HIPAA”

“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”

“Home Health Care” shall mean the continual care and treatment of an individual if all of the requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician.
3. The Home Health Care is the result of an Illness or Injury.

“Home Health Care Agency”

“Home Health Care Agency” shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare.
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
3. Meets all of the following requirements.
 - a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
 - b. It has a full-time administrator.
 - c. It maintains written records of services provided to the patient.
 - d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
 - e. Its employees are bonded and it provides malpractice insurance.

“Hospital”

“Hospital” shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center".

"HRSA"

"HRSA" shall mean Health Resources and Services Administration.

"Illness"

"Illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

"Impregnation and Infertility Treatment"

"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"

A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Independent Freestanding Emergency Department"

"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

"Injury"

"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"

"Inpatient" shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

"Institution"

"Institution" shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

"Intensive Care Unit"

"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit".

“Intensive Outpatient Services”

“Intensive Outpatient Services” shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment”.

“Leave of Absence”

“Leave of Absence” shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer’s rules, policies, procedures and practices where applicable.

“Long Term Acute Care (LTAC)”

“Long Term Acute Care (LTAC)” shall mean a long term acute care facility is a specialty-care Hospital designed for patients with serious medical problems that require intense, special treatment for an extended period of time.

“Mastectomy”

“Mastectomy” shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

“Maximum Allowable Charge”

The “Maximum Allowable Charge” shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see “No Surprises Act – Emergency Services and Surprise Bills” within the section “Summary of Benefits,”) if no negotiated rate exists, the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

“Medical Child Support Order”

“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a Participant’s Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“Medical Record Review”

“Medical Record Review” is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported

in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

“Medically Necessary”

“Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant’s Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant’s Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant’s Illness or Injury without adversely affecting the Participant’s medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of an Illness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or Covered Expenses.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant’s condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not necessarily mean that it is “Medically Necessary.” In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not “Medically Necessary” does not mean that all other services are “Medically Necessary”.

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator’s own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

“Medicare”

“Medicare” shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

“Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions”

“The Mental Health Parity Provisions” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

“Mental or Nervous Disorder”

“Mental or Nervous Disorder” shall mean any condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

“National Medical Support Notice” or “NMSN”

“National Medical Support Notice” or “NMSN” shall mean a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

“Network” or “In-Network”

“Network” or “In-Network” shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the Network’s Providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant’s identification card.

“No-Fault Auto Insurance”

“No-Fault Auto Insurance” is the basic reparations provision of a law or automobile insurance policy providing for payments without determining fault in connection with automobile Accidents.

“Non-Network” or “Out-of-Network”

“Non-Network” or “Out-of-Network” shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

“Nurse”

“Nurse” shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

“Office of Group Benefits (OGB)”

“Office of Group Benefits (OGB)” is an agency of the state of Louisiana within the Office of the Governor, Division of Administration which is authorized by Louisiana statute to provide health, accidental, and life insurance benefits to both active and retired state employees and their dependents.

“Open Enrollment Period”

“Open Enrollment Period” shall mean the time frame specified by the Plan Administrator.

“Other Plan”

“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan.

2. Any other group health plan.
3. Any other coverage or policy covering the Participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Out-of-Area”

“Out-of-Area” shall mean services received by a Participant outside of the normal geographic area supported by the Plan’s Network, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.

“Outpatient”

“Outpatient” shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician’s office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient’s home.

“Partial Hospitalization”

“Partial Hospitalization” shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

“Participant”

“Participant” shall mean any Employee, Dependent, or individual that is covered under the Plan through COBRA continuation, or retiree who is eligible for benefits (and enrolled) under the Plan.

“Participant Employer”

“Participant Employer” shall mean the Louisiana State University, the House of Representatives of the State of Louisiana, the Louisiana Senate, the Louisiana Legislative Auditors, the Louisiana Legislative Fiscal Office, and the Louisiana Legislative Budgetary Control Council. To the extent that a Successor Employer, as defined, is participating in the Plan, such an Employer shall be a Participant Employer with respect to Employees enrolled in the Plan.

“Participating Health Care Facility”

“Participating Health Care Facility” shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

“Patient Protection and Affordable Care Act (PPACA)”

The “Patient Protection and Affordable Care Act (PPACA)” means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See “Affordable Care Act”).

“Pharmacy Benefit Manager (PBM)”

“Pharmacy Benefit Manager (PBM)” shall mean a third-party administrator of prescription drug programs. PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims.

“Physician”

“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse

Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

“Plan Year”

“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Pre-Admission Tests”

“Pre-Admission Tests” shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

1. The Participant obtains a written order from the Physician.
2. The tests are approved by both the Hospital and the Physician.
3. The tests are performed on an Outpatient basis prior to Hospital admission.
4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

“Pregnancy”

“Pregnancy” shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered an Illness for the purpose of determining benefits under this Plan.

“Preventive Care”

“Preventive Care” shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: <http://www.uspreventiveservicestaskforce.org> or at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. For more information, Participants may contact the Plan Administrator / Employer.

“Prior Plan”

“Prior Plan” shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan., unless continuation of benefits applies.

“Privacy Standards”

“Privacy Standards” shall mean the applicable standards for the privacy of individually identifiable health information, as pursuant to HIPAA.

“Provider”

“Provider” shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State’s law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a “Provider” as defined herein if that entity is not deemed to be a “Provider” by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS’ determination of an entity’s status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

“Psychiatric Hospital”

“Psychiatric Hospital” shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a “Psychiatric Hospital,” the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a “Psychiatric Hospital”.

To be deemed a “Psychiatric Hospital,” the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

“Qualified Medical Child Support Order” or “QMCSO”

“Qualified Medical Child Support Order” or “QMCSO” shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

“Qualifying Payment Amount”

“Qualifying Payment Amount” means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan’s Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

“Recognized Amount”

“Recognized Amount” shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider’s billed charge or the Qualifying Payment Amount.

“Rehabilitation”

“Rehabilitation” shall mean treatment(s) designed to facilitate the process of recovery from Injury, or Illness to as normal a condition as possible.

“Rehabilitation Hospital”

“Rehabilitation Hospital” shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Illness and/or Injury. To be deemed a “Rehabilitation Hospital”, the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a “Rehabilitation Hospital”, the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

“Residential Treatment Facility”

“Residential Treatment Facility” shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

“Room and Board”

“Room and Board” shall mean a Hospital’s charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment’s, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

“Security Standards”

“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

“Service Waiting Period”

“Service Waiting Period” shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

“Skilled Nursing Facility”

“Skilled Nursing Facility” shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental or Nervous Disorders.
7. It is approved and licensed by Medicare.

“Specialty Drug(s)”

“Specialty Drug(s)” shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

“Substance Abuse” and/or “Substance Use Disorder”

“Substance Abuse” and/or “Substance Use Disorder” shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

“Substance Abuse Treatment Center”

“Substance Abuse Treatment Center” shall mean an Institution whose facility is licensed, certified or approved as a Substance Abuse Treatment Center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a “Substance Abuse Treatment Center,” the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the “Substance Abuse Treatment Center” must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

“Successor Employer”

Successor Employer. An OGB-Eligible employer that:

1. Employed a former full-time Employee of Louisiana State University; a former full-time Employee, member, or officer of the House of Representatives of the State of Louisiana, the Louisiana Senate, the Louisiana Legislative Auditors, the Louisiana Legislative Fiscal Office, and the Louisiana Legislative Budgetary Control Council. who:
 - a. Was participating in the Plan at the time of such former employment ceased;
 - b. Transferred and/or assumed full-time employment with an Office of Group Benefits (OGB) participating employer prior to January 1, 2017 other than Louisiana State University, the House of Representatives of the State of Louisiana, the Louisiana Senate, the Louisiana Legislative Auditors, the Louisiana Legislative Fiscal Office, and the Louisiana Legislative Budgetary Control Council
 - c. Elected to continue to participate in the plan in accordance with OGB rules governing interagency transfers, however such participation shall be limited to the duration of the Memorandum of Understanding between (i) the State of Louisiana, Office of the Governor, Division of Administration; (ii) the State of Louisiana, Office of the Governor, Division of Administration, Office of Group Benefits; and (iii) the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College.
 - d. Continues to remit, via payroll deduction, the Employee (and spouse and/or eligible Dependent, if applicable) portion of the monthly premium for such coverage;
2. And whose successor OGB participating employer (“Successor Employer”) remits to the Louisiana State University, the required employer portion of the monthly premium for such coverage and executes a Participation and Indemnity Agreement similar to that executed by the House of Representatives of the State of Louisiana, the Louisiana Senate, the Louisiana Legislative Auditors, the Louisiana Legislative Fiscal Office, and the Louisiana Legislative Budgetary Control Council., in favor of the Louisiana State University.

Notwithstanding any other language in this SPD to the contrary, only Employees who (i) transferred to a Successor Agency prior to January 1, 2017, and (ii) were eligible to and did elect to continue LSU First coverage at that time may continue membership in LSU First. Any Employee of LSU or any other participating agency who transfers to another state agency on or after January 1, 2017 will NOT be eligible to continue participation in LSU First under the Successor Employer or Successor Agencies provisions.

Timely Premium Remittance is required by all Agencies.

If an agency fails to remit premium payments on time, their Employees’ coverage will be cancelled. If an agency fails to comply with LSU First billing procedures, LSU First has the right to cancel employees’ coverage.

In the event that the agency does not remit premiums within 15 business days of the due date all covered employees will be terminated the 1st of the following month. LSU First will notify the agency and it is the agency's responsibility to notify the employees of their options.

Eligible members of the legislator should reference Act 366 of 2007 and refer to their Human Resource department for applicable premiums.

Participation in the Plan in Successor Agencies

Participation in the Plan in successor agencies is limited to the successor agency where the member was originally enrolled. Transfers from original successor agency to another, with or without a Participation and Indemnity Agreement voids eligibility in LSU First. Eligibility is not transferable for the duration of employment and ceases once a member moves from original successor agency to another, with or without a Participation and Indemnity Agreement.

To the extent that a Successor Employer, as defined, is participating in the Plan, such an Employer shall be a Participant Employer with respect to Employees enrolled in the Plan.

Those Retirees of a Successor Employer who were eligible for coverage under the Plan as an Employee are eligible for Retiree coverage under this Plan.

“Surgery”

“Surgery” shall in the Plan Administrator’s discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider’s license.

“Surgical Procedure”

“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Third Party Administrator”

“Third Party Administrator” shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

“Uniformed Services”

“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”

“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

“Utilization Review Manager”

“Utilization Review Manager” shall mean a team of medical care professionals selected to conduct pre-certification review, emergency admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the Utilization Management section of this document.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage

You are eligible to participate in the Plan if you are:

1. a full-time Employee of the Louisiana State University (“full-time Employee” means a person employed at 75% effort or greater per pay period (average 30 hours per week), with an appointment of more than 120 days or one academic semester).
2. a full-time Employee, member, or officer of the Louisiana Legislative Branch, comprised of the House of Representatives, the Senate, the Office of the Legislative Auditor, the Legislative Fiscal Office and the Legislative Budgetary Control Council; or
3. a former full-time Employee of the Louisiana State University; or a former full-time Employee, member, or officer of the Louisiana Legislative Branch, comprised of but not limited to, the House of Representatives, the Senate, the Office of the Legislative Auditor, the Legislative Fiscal Office and the Legislative Budgetary Control Council, who is grandfathered under provisions of a successor agency agreement prior to 01/01/2017. Employees under successor agency agreements no longer meet eligibility in the LSU First health plan if they terminate employment under the successor agency or if they transfer to a new employer.

In order to be eligible for LSU First, your employing agency must, in addition to the requirements listed above, comply with all HIPAA Policies and procedures set forth by the Plan Administrator.

In all cases, eligibility determinations shall be made in accordance with the applicable statutory and regulatory provisions of the Office of Group Benefits.

Members of Boards and Commissions

Except as otherwise provided by law, members of boards or commissions are not eligible for participation in the Plan.

Legislative Assistants

Legislative Assistants. Legislative assistants are eligible to participate in an OGB plan if they are determined to be full-time employees by the participating employer under applicable federal and state law or pursuant to R.S. 24:31.5(C), either:

- a. receive at least 60 percent of the total compensation available to employ the legislative assistant if a legislator employs only one legislative assistant; or
- b. is the *primary legislative assistant* as defined in R.S. 24:31.5(C) when a legislator employs more than one legislative assistant.

ACA Qualifying for New Hires.

Qualifying Employee: A Qualifying Employee is an Employee who is not a Regular Full-Time Employee but who averages at least 30 Hours of Service per week over the Employee’s Initial Measurement Period. Coverage will be effective on the first day of the Qualifying Employee’s Initial Stability Period, subject to completion of enrollment requirements. A Qualifying Employee will remain eligible throughout the Initial Stability Period to the extent that the Employee remains employed, subject to the Plan’s Break in Service rules.

Note: if there is a gap between the end of the Qualifying Employee’s Initial Stability Period and the start of the Qualifying Employee’s first Standard Stability Period (see below), the Qualifying Employee will remain eligible under the Plan until the day before the start of the Standard Stability Period (to the extent the employee remains employed, and subject to the Plan’s Break in Service rules.)

If a Qualifying Employee transfers to a Regular Full-Time Employee position prior to the start of the Qualifying Employee’s Initial Stability Period, the Employee will become eligible for coverage. Coverage for the new Regular

Full-Time Employee will become effective on the first day of the month following completion of the Waiting Period subject to completion of the enrollment requirements.

The Waiting Period is a period of 30 days as an Active Employee beginning on the first day of employment in an eligible class.

ACA Qualifying for Ongoing Employees.

Once an Employee has completed his or her Initial Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Standard Stability Period, provided that the Employee remains employed, and subject to the Plan's Break in Service rules. Coverage will be effective on the first day of the Standard Stability Period, subject to completion of the enrollment requirements.

Impacts of Breaks in Service.

If an Employee has no Hours of Service for a period of 13 or more consecutive weeks and then earns an Hour of Service, he or she will be treated as a New Hire upon return, and eligibility for coverage under the Plan will be determined in accordance with the New Hire rules above. If the returning Employee has had less than 13 consecutive weeks without an Hour of Service, the Employee will be treated as a continuous Employee and will be eligible for coverage under the plan upon return. Coverage will be effective on the first day of the month that coincides with or follows the date the Employee resumes Hours of Service, subject to completion of enrollment requirements.

The Employer may elect to apply the "Rule of Parity" to periods of less than 13 weeks without an Hour of Service. Under the Rule of Parity, an Employee may be treated as a New Hire if the period with no Hours of Service is at least four weeks and is longer than the Employee's period of employment immediately before the period with no Hours of Service.

The following definitions will apply to the above:

Hour(s) of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the Employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following:

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Initial Measurement Period means the 12 month period beginning on the first day of the month coinciding with or following the Employee's Date of Hire. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Initial Stability Period means the 12 month period that begins on the first day of the second calendar month after the end of the Initial Measurement Period.

Standard Measurement Period means the 12 month period that begins each year on the fifth day of October and ends on October 4. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Standard Stability Period means the 12 month period that begins on the first day of the month following the end of each Standard Measurement Period.

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

Reinstatement of Coverage

An Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least 26 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding period of employment.

A Variable Hour Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service did not exceed 26 weeks.

Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Eligibility for Dependent Coverage

The following persons are eligible to be enrolled for coverage as Dependents, provided they are not also covered as an Employee:

1. The covered Employee's legal spouse (as defined in the definition of "Dependent");
2. A Child from date of birth until the last day of the month in which the Child turns 26 years old;
3. Newborn Children, provided an Enrollment/Change Form (GB-01), together with a Birth Letter from the Hospital, is submitted to your Human Resource Department within 30 days from the date of birth of the Child (please see Dependent Verification Requirements below).
4. You may also enroll an eligible Dependent during the year if a court orders you to cover an eligible Dependent (e.g., a QMCSO). See the Section entitled "Qualified Medical Child Support Order" for more details regarding a QMCSO. Coverage will take effect the first day of the month following the date of receipt by your Employer of all required forms prior to the fifteenth of the month, or the first day of the second month following the date of the receipt by your Employer of all required forms on or after the fifteenth of the month.

Note: No one may be enrolled simultaneously as an Employee and as a Dependent under the Plan, nor may a Dependent be covered by more than one Employee. If a covered spouse chooses to be covered separately at a later date and is eligible for coverage as an Employee, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase benefits.

Dependent Verification Requirements

To deter fraud and abuse and assure the proper use of public funds and Plan Members' premium dollars, the Plan requires proof that the Dependents covered are legal Dependents of the Employee. LSU First reserves the right to perform an eligibility audit, in addition to initial proof requirements, at any time.

Newly covered Employees/Retirees

Newly covered Employees/Retirees are required to provide written proof that each Dependent covered under the Employee's Health Plan is his/her actual legal Dependent. All Employees must present appropriate written verification for all currently covered Dependents to their HR department on his/her Campus.

Documentation Required for All Employees/Retirees

Written Verification Required for Dependents:

Employees/Retirees must provide proof of the status of each covered Dependent to your Human Resource Department.

Below is a list of categories of Dependents and the proof that must be presented at the time of enrollment to cover these Dependent(s):

1. Spouse: Certified copy of marriage certificate indicating date and place of marriage.
2. Child under age 26:
 - a. Certified copy of birth certificate listing Plan Member as parent. For newborn Children, a birth letter from the Hospital will suffice until a birth certificate is issued. The birth certificate should be submitted to your Human Resources Department no later than six months from the Child's date of birth; or
 - b. Certified copy of legal acknowledgment of paternity signed by Employee/Retiree; or
 - c. Certified copy of adoption decree naming Plan Member as adoptive parent.
3. Stepchild: Certified copy of marriage certificate to spouse and birth certificate listing spouse as natural or adoptive parent.
4. Child placed with your family for adoption by agency adoption or irrevocable act of surrender for private adoption who lives in your household and/or will be included as dependent on your federal income tax return for current or next tax year:
 - a. Certified copy of adoption placement order showing date of placement; or
 - b. Copy of signed and dated irrevocable act of surrender.
5. Child (unmarried) for whom you have been granted guardianship or legal custody who lives in your household and/or will be included as dependent on your federal income tax return for current or next tax year:

Certified copy of signed legal judgment granting you legal guardianship or custody.

Note: Court-ordered legal custody/guardianship dependents will be covered until age 18 or the end of the month the custody order expires, whichever is earlier.
6. Grandchild (unmarried) for whom you have legal custody or guardianship and who is dependent on you for support:

Certified copy of signed legal judgment granting you legal guardianship or custody.

Note: Grandchildren covered under the Plan prior to January 1, 2016 will remain eligible provided the covered Dependent parent remains covered.
7. Child age 26 or older who is incapable of self-sustaining employment due to mental retardation or physical incapacity and who was covered prior to and upon attainment of age 26. Documentation listed above, together with an application for continued coverage and supporting medical documentation which must be received by WebTPA prior to the child's attainment of age 26, as well as additional medical documentation of the child's continuing condition periodically upon request.

If you have questions about the Dependent verification policy, contact your local Human Resources Management Department.

Eligibility for Retiree Coverage

A person is eligible for retiree coverage from the first day that he or she meets one of the following requirements:

1. Is a retired Employee of the Employer.
2. Those Retirees of a Successor Employer who were eligible for coverage under the Plan as an Employee are eligible for Retiree coverage under this Plan. Retirees from successor agencies who move to an OGB plan during an Open Enrollment or Qualifying Life Enrollment window will no longer be eligible for LSU First.
3. If the Employee is retired, and the Employee or spouse qualifies for Medicare for reasons other than obtaining the age of 65, the Plan will pay secondary to Medicare for that person.

The Plan reserves the right to periodically audit for Medicare eligibility.

Once a retiree and all covered family members are enrolled in Medicare Part A and Part B primary and are therefore eligible to enroll in the LSU First Medicare Retiree Health Plan, the retiree is no longer eligible for the LSU First Plan. If the retiree and and/all covered dependents are enrolled in Medicare Part A and Part B such that Medicare is paying primary for all covered family members, they will all automatically be terminated from the Plan and enrolled into the LSU First Medicare Retiree Plan or another state-sponsored health plan for which they are eligible. Please see the section entitled "This Benefit Plan and Medicare" for additional information.

Surviving Dependent/Spouse Eligibility Requirements

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage within the allotted amount of time.
 - a. The surviving legal spouse of an Employee or Retiree may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a Group Health Plan other than Medicare;
 - b. The surviving Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a Group Health Plan other than Medicare or until attainment of the termination age for Children, whichever occurs first;
 - c. Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees and Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits;
 - d. Coverage provided by the Civilian Health and Medical Program for the Uniform Services (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a Dependent Child.
2. A Surviving Spouse or Dependent cannot add Dependents to continued coverage other than a Child of the deceased Employee (born before or after the Employee's death) with a Qualifying Life Event.
3. Participant Employer/Dependent Responsibilities:
 - a. It is the responsibility of the Participant Employer and surviving covered Dependent to notify their Human Resource Department within 30 days of the death of the Employee or Retiree; The Human Resource Department will notify the surviving Dependents of their right to continue coverage;
 - b. Application for continued coverage must be made in writing to their Human Resource Department within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;
 - c. Coverage for the surviving Spouse under this section will continue until the earliest of the following:
 - i. Failure to pay the applicable premiums, contributions, and surcharges timely;
 - ii. Eligibility of the surviving spouse under a Group Health Plan other than Medicare.
 - d. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:
 - i. Failure to pay the applicable premiums, contributions, and surcharges timely;
 - ii. Eligibility of the surviving Dependent Child for coverage under any Group Health Plan other than Medicare; or
 - iii. The attainment of the termination age for Children
4. The provisions of paragraphs 1 through 3 in this subsection are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.
5. The plan reserves the right to periodically audit for eligibility.

Effective Dates of Coverage; Conditions

1. Employee Effective Dates of Coverage (New Employee and Transferring Employee)
Coverage for each Employee who enrolls and agrees to make the required payroll contributions to his Participant Employer is effective as follows:
 - a. Coverage will be effective the 1st of the month following the first full calendar month of employment. For example, an Employee hired on July 1st will have an effective date of August 1st; an Employee hired on July 18th will have an Effective Date of September 1st.
 - b. Employee coverage will not become effective unless the Employee completes the onboarding process with their applicable employer within 30 days following the date of employment.
 - c. An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption.
2. Dependent Effective Date of Coverage/Notification

- a. Newly Acquired Dependent – When there is a change in family status (e.g. marriage, birth of Child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within 30 days of the date of the event. When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the 15th day of the month. If the date of change occurs on or after the 15th day of the month, an additional premium will not be charged until the first day of the following month.
- b. Birth of a Dependent Child -- A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, newborn care and Preventive Care if the Child is added within 30 days of the date of birth. In order to add a newborn Child, you must submit an Enrollment/Change Form and Birth Letter to the Human Resource Management Department. If written notification to add a newborn Child is received by the Plan Administrator AFTER the 30 day period immediately following the Child's date of birth, the Child is considered a late enrollee and not eligible for the Plan until the next Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.
- c. Dependents of Retirees -- Coverage for Dependents of Retirees will be effective on the first day of the month following the date of retirement if the Employee and his Dependents were covered immediately prior to retirement. Coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement will be effective on the date of marriage for new spouses, the date of birth for newborn Children, or the Date Acquired for other classifications of Dependents. Application must be made within 30 days of the date of eligibility for coverage.

NOTE: It is the Employee's responsibility to notify their Human Resource Department of any change in classification of coverage that affects the Employee's contribution amount. If failure to notify the plan of loss of eligibility the plan reserves the right to correct eligibility based on the effective date of loss of eligibility and correct the premiums on the first day of the following month.

3. Retiree Effective Date of Coverage

Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions (for example, if retired July 15, coverage will begin August 1). If the retiree and covered dependents are eligible for Medicare, they will automatically be terminated from the Plan and enrolled into the LSU First Medicare Retiree Plan or another state-sponsored plan for which they are eligible.

Change of Classification

The Employee must notify their Human Resource Department when a Dependent is added to or deleted from the Employee's coverage that results in a change in the Coverage Tier. Notice must be provided within 30 days of the addition or deletion.

Change in Coverage

1. When there is a change in family status (e.g., marriage, birth of Child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within 30 days of the date of the event.
2. When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the 15th day of the month. If the date of change occurs on or after the 15th day of the month, an additional premium will not be charged until the first day of the following month.

NOTE: It is the Employee's responsibility to notify their Human Resource Department of any change in classification of coverage that affects the Employee's contribution amount. If failure to notify the plan of loss of eligibility, the plan reserves the right to correct eligibility based on the effective date of loss of eligibility and correct the premiums on the first day of the following month. Dependents who gain eligibility

that are not reported within the 30 days of a qualified life event may not be added until the Open Enrollment period.

Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period. The Special Enrollment rules are described in more detail within the Eligibility for Coverage section.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
 - a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
 - b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
 - c. The eligible Employee or Dependent moved out of a Health Maintenance Organization (HMO) service area with no other option available.
 - d. The Plan is no longer offering benefits to a class of similarly situated individuals.
 - e. The benefit package option is no longer being offered and no substitute is available.
 - f. The employer contributions under the other coverage were terminated.

Special enrollment rights will not be available to an Employee or Dependent if either of the following requirements is met:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan and the request is made within 30 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 22.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, legal guardianship, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 30 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 22. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if one the following occurs:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, legal guardianship, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, as of the date of marriage.
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a Dependent's birth, as of the date of birth.
4. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

HIPAA Retiree Special Enrollment

Retirees will not be eligible for special enrollment, except under the following conditions:

1. Retirement began on or after July 1, 1997;
2. The Retiree can document that Creditable Coverage was in force at the time of the election not to participate or continue participation in the Plan;
3. The Retiree can demonstrate that Creditable Coverage was maintained continuously from the time of the election until the time of requesting special enrollment;
4. The Retiree has exhausted all COBRA and/or other continuation rights and has made a formal request to enroll within 30 days of the loss of other coverage; and
5. The Retiree has lost eligibility to maintain other coverage through no fault of his/her own and has no other Creditable Coverage in effect.

Medicare Advantage Option for Retirees

Retirees who elect participation in a Medicare Advantage plan not sponsored by LSU or OGB will not be allowed to reenroll in a plan offered by OGB or LSU upon withdrawal from or termination of coverage in the Medicare Advantage plan.

Tricare for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life ("TFL") option on and after October 1, 2001, who cancel coverage with the Plan upon enrollment in TFL may re-enroll in the Plan in the event that the TFL option is discontinued or its benefits significantly reduced.

Open Enrollment

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Employees who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. A Participant who fails to make an election during the Open Enrollment Period will automatically retain his or her present coverages. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

“Open Enrollment Period” shall mean the time frame specified by the Plan Administrator.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Child or Children shall remain eligible for benefits under the plan until the end of the month the child or children turn 18 or the end of the month the custody order expires, whichever is earlier. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of “National Medical Support Notice.”
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan’s default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
 - a. Whether the Child is covered under the Plan.
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
 - a. Be in writing.
 - b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
 - c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the Child, or the Child's custodial parent or legal guardian, shall be made to the Child, the Child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the Child.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation

is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for themselves under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. The date upon which he or she requests that such coverage be terminated, on the condition that such request is made on or before such date.
3. The date in which the agency reports to plan administration that the Employee has failed to pay premium contributions to the plan or the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for themselves to which he or she has agreed in writing.
4. The date upon which the Employee is no longer eligible for such coverage under the Plan.
5. The date following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Retiree Coverage

The coverage of any retiree who is covered under the Plan will terminate at the end of the month of the following dates:

1. The date of termination of the Plan.
2. End of the month of the death of the covered retiree.
3. The date of the expiration of the last period for which the retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for themselves to which he or she has agreed in writing.
4. The date the covered retiree becomes eligible for coverage under another Employer's health plan.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate at the end of the month of the following dates:

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for themselves under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such disability or inability.
 - b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination.
 - c. Upon the Child's no longer being dependent on the Employee for his or her support.
6. The day immediately preceding the date such person is no longer a Dependent, except for Dependent Children, as defined herein, except as may be provided for in other areas of this section.
7. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.

8. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month in which the dependent turns 18 or the end of the month the custody order expires, whichever is earlier.
9. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

CONTINUATION OF COVERAGE

Employer Continuation Coverage

Eligible Participants may seek to continue coverage upon the occurrence of any of the following:

If an enrollee is allowed an approved leave of absence by his/her participating employer, the enrollee may retain the coverage for up to one year if the premium is paid. Failure to pay the premium will result in cancellation of coverage. The enrollee and/or the participating employer shall notify OGB within 30 days of the effective date of the leave of absence.

Leave of Absence Without Pay (Employer Contributions to Premiums)

A covered Employee who is granted leave of absence without pay due to a service (employment) related injury may continue coverage and the Participant Employer shall continue to pay its portion of health plan premiums for up to twelve (12) months if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

A covered Employee who suffers a service (employment) related injury that meets the definition of a total and permanent disability under the worker's compensation laws of Louisiana may continue coverage and the Participant Employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.

A covered Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Participant Employer may continue to pay its portion of premiums if the Employee continues his/her coverage. Failure of the Employee to pay the premium will result in cancellation of coverage.

Leave of Absence Without Pay (No Employer Contributions to Premiums)

An Employee granted leave of absence without pay for reasons other than those stated above may continue coverage for a period up to 12 months upon the Employee's timely payment of the full premiums due. The employees Human Resource Department must be notified by the Employee and the Participant Employer within 30 days of the effective date of the Leave of Absence.

The above noted leave(s) run concurrently with FMLA, USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence. At the end of the period(s) listed above, the Participant's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

Continuation During Family and Medical Leave Act (FMLA) Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Families First Coronavirus Response Act (FFCRA)

The Families First Coronavirus Response Act (FFCRA) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020. Eligibility will be extended through any such leave in the same manner as for traditional FMLA leave.

Eligible Employees

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons. Employees who have been employed for at least 30 days prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave to care for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons.

Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. To continue coverage, Participants must comply with the terms of the Plan, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Military Service Relief Act

Pursuant to Louisiana law (La. R.S. 29:401, et seq.), if you leave employment due to service in the uniformed services, you have the right to maintain your coverage under the Plan by payment to the Plan of the sum equal to that which would have been deducted from your compensation for such coverage. For additional information, contact your Human Resources Management Department.

Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan certain Participants and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The

Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced.
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced or Legally Separated from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced or Legally Separated.
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Employer, and that bankruptcy results in the loss of coverage for any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary, with the bankruptcy being deemed to be the Qualifying Event. The retired Employee's Dependent(s) (if applicable) will also become Qualified Beneficiaries if the bankruptcy (Qualifying Event) results in a loss of their coverage under the Plan.

Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events

In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse.
2. **Notice of Child's Loss of Dependent Status:** Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. **Notice of a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. **Notice Regarding Disability:** Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.

5. **Notice Regarding End of Disability:** Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Notification must be received by the COBRA Administrator. The COBRA Administrator is:

WebTPA
P.O. Box 2383
Grapevine, TX 76099
Phone: 1-800-758-2525
Fax: 1-469-417-1733

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for Providing the Notice

For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required Contents of the Notice

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
 - a. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
 - b. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
 - c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
 - d. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
 - e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
 - f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.

14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Dependent of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to thirty-six months after the date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this eighteen month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage

Disability can extend the 18 month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies the COBRA Administrator. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18 month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the Plan Administrator or COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce or Legal Separation, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

Shorter Duration of COBRA Continuation Coverage

COBRA establishes required periods of coverage for continuation of health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage will terminate immediately, unless otherwise noted, upon the occurrence of any of the following events:

- Contributions are not paid in full on a timely basis,
- The Plan Sponsor ceases to maintain any group health plan,
- The Qualified Beneficiary begins coverage under another group health plan after electing continuation coverage,
- The Qualified Beneficiary enrolls in Medicare Part A or B after electing continuation coverage (except as stated under COBRA's special bankruptcy rules),
- The Qualified Beneficiary engages in fraud or other conduct that would justify termination of coverage of a similarly situated participant or beneficiary not receiving continuation coverage, or
- If covered under an 11-month disability extension, there is a final determination that the Qualified Beneficiary is no longer disabled for Social Security Purposes (coverage shall terminate on the first day of the month at least 30 days after the determination is made that the Qualified Beneficiary is no longer disabled).

If COBRA Continuation Coverage is terminated early, the Plan will provide the Qualified Beneficiary with an early termination notice.

Employee Notice of Other Enrollment

If the Qualified Beneficiary becomes enrolled in Medicare or under another group health plan after electing COBRA Continuation Coverage, the Qualified Beneficiary must notify the COBRA Administrator in writing immediately.

Contribution and/or Premium Requirements

The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator must allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

Additional Information

Please contact the COBRA Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

WebTPA
P.O. Box 2383
Grapevine, TX 76099
Fax: 1-469-417-1733

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about a Participant's rights under COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit <https://www.dol.gov/agencies/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

Important information may be distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who has been previously identified in this Continuation of Coverage section) informed of any changes in the addresses of family members.

GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports, or for duplicating or providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Involving a Participant who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication, even if the cause of the Illness or Injury is not related to the use of alcohol. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Autopsy. Unless requested by the Plan.

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise. Services or supplies used, prescribed, or recommended in connection with any excluded or non-covered treatment or procedure, including, without limitation, any services or supplies related to or arising out of any non-covered treatment or procedure (including any complications arising from the non-covered treatment or procedure), **regardless of whether such services or supplies are Medically Necessary. Member must contact WebTPA to determine eligible benefits.**

Confined Persons. That are for services, supplies, and/or treatment of any Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal institution.

Cosmetic Surgery. That are incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) immediate repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. Benefits are only available if the illness, injury or birth occurs while coverage is in force. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

The following may be covered if medically necessary:

- Rhinoplasty
- Blepharoplasty or brow ptosis
- Breast enlargement, or implantation of breast implants as specifically provided elsewhere in this Plan.

The following services are not covered, whether or not medically necessary:

- Implantation, removal or reimplantation of penile prosthesis
- Diastasis recti
- Benign gynecomastia
- Removal or replacement of an existing breast implant previously placed for cosmetic purposes.
- Panniculectomy, abdominoplasty, thighplasty, brachioplasty or mastopexy.

Custodial Care. Services provided mainly for rest cures, the ease of a household, sanitarium care or that do not restore health, or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan.

Diagnostic inpatient admission if the test can be performed on an outpatient basis

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Family Member. Those related by blood, marriage or residing in the same residence as the prescriber.) Prescription services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother, sister, aunt or uncle, whether the relationship is by blood or exists in law or as determined by Plan Administrator.

Foreign Resident. That are received outside of the United States to a Participant living outside of the United States or its territories. Expenses for care or treatment received outside of the United States or its territories, except for unexpected emergency situations while traveling, are **excluded**. For emergent care in other countries, you will need to pay your bill and submit it along with any applicable documentation from the provider to the Claim Administrator for reimbursement pursuant to applicable Plan provisions. We recommend you pay with a credit card as it will automatically convert the amount paid into U.S. dollars.

Foreign Travel. That are received outside of the United States, unless in an unexpected, emergency situation. Products purchased outside of the United States, unless in an unexpected, emergency situation

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Illegal Acts. That are for any Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to felonies, even if the cause of the Illness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Illness Incurred while the Participant was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, even if the cause of the Illness or Injury is not related to the use of the controlled substance, drug, hallucinogen or narcotic. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Long Term Care. That are related to long term care.

Marijuana. For marijuana or marijuana-derived substances or compounds (like THC/CBD oil), even if the Participant has a prescription and marijuana is legal under the laws of the state in which he or she lives.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service. That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Covered Provider. That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Not Specified As Covered. That are not specified as covered under any provision of this Plan.

Occupational. That are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational Injury medical coverage is available.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury, and performed by an appropriate Provider.

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Participant actually had such mandatory coverage. Any claims which arise in connection with an automobile accident for which the policy provides an option for medical coverage are excluded. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law.

Provider Error. That are required as a result of unreasonable Provider error.

Services or confinements ordered by a court or law enforcement officers that are determined by the Medical Necessity Review Organization retained by the Plan Administrator to make such determinations not to be Medically Necessary (an initial court-ordered exam for a Dependent Child under age 18 is considered Medically Necessary)

Subrogation, Reimbursement, and/or Third Party Responsibility. That are for an Illness or Injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Unreasonable. That are not reasonable in nature or in charge (see definition of Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

War/Riot. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Claimants complying with the following:

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and applicable law. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and Exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. **Pre-service Claims.** A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim".

Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim". In such circumstances, the Claimant is urged to obtain the applicable care without delay and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.
3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

Filing Claims For Benefits

When you receive care from your healthcare Provider, you will present your Plan ID card. Your provider should submit a claim for payment directly to WebTPA, the Claim Administrator. The Claim Administrator will calculate the appropriate reimbursement amount, which will be deducted from your Health Reimbursement Account based on your balance at the time WebTPA processes your claim. Once you have exhausted your Health Reimbursement Account, you will be responsible for any additional Covered Expenses you incur up to the extent of your Remaining Deductible, if any. Once your Deductible is met, the Plan will pay a portion of your Covered Expenses until you meet the Out-of-Pocket Maximum (if applicable) — after which the Plan will pay 100% of any additional Covered Expenses you incur. If your provider does not file a claim on your behalf, follow the procedures below.

Remember: By utilizing a First Choice Provider, you incur no Remaining Deductible or Coinsurance responsibility. Also, Tier 1 Generic Drugs are paid at 100% after exhaustion of the HRA.

When your claim is processed by WebTPA, two important dates are used:

1. The date on which you received a service from your provider is used to process claims for the Plan. This allows your Deductible, Coinsurance, and Out-of-Pocket Maximum to be applied as effective on the date when you receive healthcare services.
2. The date on which WebTPA processes your claim is used when deducting from your HRA. This allows your HRA to be available for use when your claim is paid.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 90 days of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. The amount of charges, which reflect any applicable PPO re-pricing, if any.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:
 - a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
 - b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
 - c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
 - i. The end of the period afforded the Claimant to provide the information.
 - ii. The Plan's receipt of the specified information.
 - d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.
2. Pre-service Non-urgent Care Claims:
 - a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of

the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.

- b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

2. Concurrent Claims:

- a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
- b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
- c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
- d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i.	Notification to Claimant	30 days
ii.	Notification of Adverse Benefit Determination on appeal	30 days

2. Post-service Claims:

- a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
- b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
- c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

3. Extensions:

- a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
- b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- c. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
4. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of Pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures.
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.

6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for First Level Appeal

The Claimant must file the appeal in writing (although oral appeals are permitted for Pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. All Pre-service claims must be sent to the Utilization Review Manager. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, follow the instructions on the Notice of Adverse Benefit Determination or contact the following:

Phone: 1-855-346-LSU1
Email: helpme@webtpa.com

For Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

WebTPA
8500 Freeport Parkway, Suite 400
Irving, TX 75063
Phone: 1-855-346-LSU1
Email: helpme@webtpa.com

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's member identification number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the summary plan description on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

The decision by the Plan Administrator or other appropriately named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Deemed Exhaustion of Internal Claims Procedures and De Minimis Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion of a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Autopsy

Upon receipt of a claim for a deceased Claimant for any condition, illness, or injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan Exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by

the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or Exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimant and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.

3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

Medicaid Coverage

A Claimant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Limitation of Action

A Claimant cannot bring any legal action against the Plan to recover reimbursement until 90 days after the Claimant has properly submitted a request for reimbursement as described in this section and all required reviews of the Claimant's claim have been completed. If the Claimant wants to bring a legal action against the Plan, he or she must do so within two years from the expiration of the time period in which a request for reimbursement must be submitted or he or she loses any rights to bring such an action against the Plan.

A Claimant cannot bring any legal action against the Plan for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within two years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Third Party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third Party Administrator to pay claims.
9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.

10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

NOTE: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

Summary of Material Reduction (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give the Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

Standard Coordination of Benefits

The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

Benefits Subject to This Provision

The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance

If at the time of Injury, Illness, disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Covered Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the provision entitled “Application to Benefit Determinations”, the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses a claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.
3. If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. If two or more health plans cover a Dependent Child of divorced or separated parents, benefits for the Child are determined as follows:
If under a court decree the parents have joint custody but the decree doesn’t state who is responsible for the Child’s healthcare expenses, benefits will be coordinated the same as for the Children of married parents, described previously.
 - b. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - c. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Covered Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for

payment of such Covered Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

This Benefit Plan and Medicare

Except as noted below, if a Plan Participant is eligible for Medicare for any reason, and Medicare is or would be the primary payer for that Plan Participant, NO MEDICAL BENEFITS will be paid or payable under this Plan except Benefits payable as secondary to the Part(s) of Medicare in which the individual is enrolled.

When an individual is covered by this Plan and by Medicare, Medicare laws and regulations govern the order of Benefit, that is, whether Medicare is the primary or secondary payer.

1. The following applies to Retirees who have attained the age of sixty five (65) **before** July 1, 2009 and their covered spouses:

a. Eligible for Medicare. If the Plan Participant is enrolled in Medicare Part A and Part B, Medicare is the primary payer. Eligible Expenses under this Plan will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. Eligible Expenses not covered by Medicare are payable.

If the Plan Participant is not enrolled in Medicare Part A, NO BENEFITS will be paid or payable under this Plan for claims that would be eligible for payment under Medicare Part A.

If the Plan Participant is not enrolled in Medicare Part B, this Plan is the primary payer for claims that would be eligible for payment under Medicare Part B, provided the Retiree has paid the applicable premium for Retirees with No Medicare.

b. Not Eligible for Medicare. If a Plan Participant is not eligible for Medicare under any possible eligibility criteria, and therefore is not enrolled in Medicare, that Plan Participant must provide written verification of current Medicare ineligibility from the Social Security Administration or its successor to the Plan Administrator upon request.

As long as the Plan Administrator has current, acceptable proof of Medicare ineligibility on file, this Plan is the primary payer, and Benefits will be paid without regard to Medicare coverage, provided the Retiree has paid the applicable premium for Retirees with No Medicare.

If a Plan Participant does not provide acceptable proof of Medicare ineligibility upon request, NO MEDICAL BENEFITS will be paid or payable under this Plan.

2. The following applies to Retirees who have attained the age of sixty five (65) **on or after** July 1, 2009 and their covered Spouses:

a. Eligible for Medicare. A Retiree or Spouse of a Retiree who attains or has attained age sixty five (65), when either has sufficient earnings credits to be eligible for Medicare or is eligible for Medicare under any possible eligibility criteria and Medicare is or would be the primary payer for that Plan Participant, **MUST ENROLL** in Medicare Part A AND Medicare Part B in order to receive full Benefits under this Plan.

Benefits are payable as secondary to the Part of Medicare in which the individual is enrolled, except as specifically provided in this Benefit Plan. Eligible Expenses under this Plan will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. All provisions of this Plan, including all provisions related to Deductibles, Coinsurance, limitations and exclusions will be applied.

If such Retiree or Spouse of a Retiree is not enrolled in Medicare Part A and Medicare Part B, NO BENEFITS will be paid or payable under this Plan except Benefits payable as secondary to the Part of Medicare in which the individual is enrolled. A Spouse who is age 65 or older and is not enrolled in Medicare Part A and Part B as required may be terminated from this Plan.

b. Not Eligible for Medicare. If a Plan Participant is not eligible for Medicare under any possible eligibility criteria, and therefore is not enrolled in Medicare, that Plan Participant must provide written verification of current Medicare ineligibility from the Social Security Administration or its successor to the Plan Administrator upon request.

As long as the Plan Administrator has current, acceptable proof of Medicare ineligibility on file, this Plan is the primary payer, and Benefits will be paid without regard to Medicare coverage, provided the Retiree has paid the applicable premium for Retirees with No Medicare.

If a Plan Participant does not provide acceptable proof of Medicare ineligibility upon request, NO MEDICAL BENEFITS will be paid or payable under this Plan unless Medicare has paid primary. A Spouse who is age 65 or older and does not provide acceptable proof of Medicare ineligibility upon request may be terminated from this Plan.

Coordination with Medicaid

A person's eligibility for coverage under this Plan shall not be affected by the fact that he or she is eligible for or is provided medical assistance under Medicaid, that is, a state plan for medical assistance approved under Title XIX of the Social Security Act. In addition, this Plan's coordination of benefits rules will not apply to benefits a Participant is entitled to receive under Medicaid.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Illness, or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of applicable law.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Pronouns

Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

No Waiver or Estoppel

All parts, portions, provisions, and conditions in the Plan and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no waiver of or estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan Sponsor's obligation with respect to such payments.

In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements

All statements made by the Plan Sponsor or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

HRA COMPARED TO FLEXIBLE BENEFIT PLAN

If your Employer has adopted a Section 125 Flexible Benefit Plan, commonly referred to as a “cafeteria plan”, your Plan premiums may be paid pursuant to a salary reduction arrangement. You are not permitted to make any contribution to your HRA, whether made on a pre-tax or after tax basis. Your HRA is an “unfunded” account, and benefits are payable solely from the general assets of the Plan.

See your local Human Resources or Benefits representative for more details and current rates regarding an available Flexible Benefit Plan.

SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out of pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Provider Networks

Three Provider Networks are available to all Members:

- First Choice Provider Network
- Verity HealthNet Providers
- Aetna Signature Administrators PPO Network (Aetna ASA)

First Choice Provider Program

After your HRA is exhausted, LSU First pays 100% when you use a First Choice Provider for Covered Medical Services. The Remaining Deductible (the Deductible less the HRA) and Coinsurance component are not applicable when using a First Choice Provider.

In-Network Providers

When you access a Provider through either Aetna ASA or Verity HealthNet, you'll save money. In-Network Providers have agreed to a Contract Rate. Therefore, you can make your HRA go further by using an In-Network Provider. The In-Network Provider cannot charge any amount in excess of the Contract Rate. In addition, the Coinsurance component will pay a greater percentage of Covered Medical Expenses billed by an In-Network Provider as compared to an Out-of-Network provider.

- *Aetna ASA Providers*
 - Aetna provides nationwide access to Providers.
- *Verity HealthNet Providers*
 - Verity HealthNet offers Members robust local-only Provider coverage.

To Locate a Provider

To determine if a Provider is in any of the networks above, log onto www.webtpa.com and click on "Find a Provider." You may also call 1-855-346-LSU1 and a customer service representative can locate a Provider in one of the networks.

Be sure to ask for a provider who is "contracted with" either First Choice, Aetna ASA, or Verity to find a provider in the specific networks. A provider contracted with the Aetna ASA or Verity networks will accept your LSU First Plan, but may not be a part of the First Choice network. You must specify that you are looking for a provider "contracted with" First Choice if you want to avoid Out-of-Pocket expenses, other than copays, deductible and coinsurance.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Please also be aware that some First Choice facilities may use ancillary providers such as emergency room physicians, pathologists, radiologists, or anesthesiologists who are not First Choice Providers and who

may or may not be Aetna ASA or Verity Network providers. If you are scheduling a procedure at a facility, contact the facility directly to find out what ancillary providers it may use.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act (“NSA”), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan’s Covered Expense was the Recognized Amount, regardless of the Plan’s actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider’s billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

Out-of-Network Providers

An Out-of-Network Provider is a health care provider that has not entered into a contract or agreement directly with a network of providers accessed by LSU First. Providers cannot be required to become Contracted Health Care Providers, and they cannot be prevented from collecting from the patient any amounts in excess of the Contract Rate.

What If Services Are Not Available from a Network Provider?

If you require a Medically Necessary service that is not available from an In-Network Provider or Facility within 30 miles of your location **and** the use of the Out-of-Network Provider is approved by Medical Management, then Covered Medical Expenses will be reimbursed at 80% of the Maximum Allowable Charge, as determined by the Plan. You may still be responsible for any amounts in excess of the Maximum Allowable Charge.

To ensure that benefits for services from an Out-of-Network Provider qualify to be reimbursed at 80% of the Maximum Allowable Charge, prior approval must be obtained by calling 1-855-346-LSU1.

Except as outlined in “No Surprises Act – Emergency Services and Surprise Bills” below, if the charge billed by a Out-of-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

To receive benefit consideration, Participants may need to submit claims for services provided by Out-of-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

How Your Choice of Provider Affects You

You may seek healthcare services from any Provider. Remember, an Out-of-Network Provider is a Non-Contracted Healthcare Provider. If you receive services from a Non-Contracted Provider, you are responsible for any amount the provider charges in excess of the Plan allowed amount. There is no limit to what an Out-of-Network provider can charge you, and any amount you pay in excess of the Plan allowed amount does not apply to your deductible or Out-of-Pocket Maximum.

The following example is for illustration purposes at employee only tier and may not be a true reflection of the Plan Participant's actual out of pocket amounts.

Category	First Choice Provider	In-Network Provider (Aetna ASA or Verity HealthNet Providers)	Out-of-Network Provider (Non-Contracted Provider)
Billed Charge for Procedure	\$20,000	\$20,000	\$20,000
Plan Allowed Amount (Maximum Allowable Charge)	\$5,500	\$7,000	\$3,000
Amount Paid from HRA	\$500	\$500	\$500
Deductible (Your portion of the Deductible)	\$0	\$500	\$500
Co-Insurance Paid by You after deductible and HRA	0% (\$0)	20% of Plan Allowed Amount (\$1,200)	40% of Maximum Allowable Charge (\$800)
Additional Amount Provider May Bill You (Only when you use an Out-of-Network Provider)	\$0	\$0	(\$20,000 Billed Charge - \$3000 Maximum Allowable)
Your Total Expense for this Outpatient Surgical Procedure	\$0	\$1,700 (\$500 Deductible + \$1,200 Co-Insurance)	(\$500 Deductible + \$800 Co-Insurance + \$17000 Above the Maximum Allowable)

What If I am Traveling?

If you are traveling and you need medical care, you should contact Customer Service at 1-855-346-LSU1 or log onto the website at www.lsu.edu/lsufirst for assistance in locating the nearest In-Network Provider. If you need emergency care while traveling, please get the care you need, and the Plan will pay Covered Expenses at 80% of Maximum Allowable Charge (subject to the Deductible, Coinsurance, and other restrictions) regardless of the provider's network status. Note: You may still be responsible for any amounts in excess of the Maximum Allowable Charge if you use an Out-of-Network provider.

What If I am Traveling Outside of the United States?

Expenses for care or treatment received outside of the United States or its territories, except for unexpected emergency situations while traveling, are **excluded**. For emergent care in other countries, you will need to pay your bill and submit it along with any applicable documentation from the provider to the Claim Administrator for reimbursement pursuant to applicable Plan provisions. We recommend you pay with a credit card as it will automatically convert the amount paid into U.S. dollars.

Specialty Networks

In order to access these services, Members should contact Plan Medical Management at 1-855-346-LSU1

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. Although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in

balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Network Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the website address.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

- 1) is undergoing a course of treatment for a serious and complex condition from a specific Provider,

- 2) is undergoing a course of institutional or Inpatient care from a specific Provider,
- 3) is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
- 4) is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
- 5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

HOW LSU FIRST WORKS

The LSU First medical benefit consists of three separate components:

1. Deductible (member responsibility)
2. HRA (employer-funded)
3. Coinsurance for Covered Medical Services up to the Medical Maximum Out-of-Pocket which includes HRA, Remaining Deductible, and Coinsurance)

1. The Deductible

The amount of your Deductible is based on your Coverage Tier and the effective date of your coverage.

2. The HRA

LSU funds 100% of your HRA at the beginning of each Plan Year (January 1). The HRA pays for 100% of Covered Medical Expenses (except co-pays and penalties) from any Healthcare Provider until the HRA is exhausted. HRA funds may not be used to pay ER copay, penalty amounts or balance billed amounts or pharmacy expenses.

Annual HRA Contribution

<i>Coverage Tier</i>	<i>Option 1</i>
Employee Only	\$500
Employee plus Spouse	\$750
Employee plus Child(ren)	\$750
Family	\$1,000

**Note: HRA/Deductible are pro-rated for late enrollees, details will be provided below.*

HRA Rollover

Any balance in your HRA at the end of the Plan Year will be rolled over to the next Plan Year up to a maximum combined total of current year and rollover amounts (see chart below). Rollover funds will be used to pay for all Covered Medical Expenses(except for co-pays or penalties), including First Choice Providers. Your combined total HRA Rollover and new allocations of HRA may not exceed the following amounts in a Plan Year:

Annual Total HRA Maximum

<i>Coverage Tier for the new plan year</i>	
Employee Only	\$1,000
Employee plus Spouse	\$1,500
Employee plus Child(ren)	\$1,500
Family	\$2,000

If you exhaust your HRA, you are responsible for meeting your Remaining Deductible and paying your share, if any, of additional healthcare costs you incur during the Plan Year. Remember, claims for First Choice Providers will be paid at 100% (except for copays and penalties) by LSU First after your HRA is exhausted.

IMPORTANT NOTE: The HRA and Flexible Spending Accounts

While your HRA is similar to a flexible spending account, they are not the same thing, and they are used for different purposes. You may participate in both if you feel that best meets your family’s needs. Keep in mind:

- The HRA is only available if you enroll in LSU First — you cannot elect it separately and you cannot drop out of it unless you drop out of LSU First as well. Your participation in a flexible spending account is not related to your participation in LSU First.
- While the HRA and a flexible spending account may cover some of the same types of expenses, a flexible spending account may be funded with pre-tax contributions under a salary reduction arrangement. You are not permitted to contribute any amount of your income to the HRA.

Expenses reimbursed through the HRA cannot also be reimbursed through the flexible spending account.

Overview of the Remaining Deductible

Once your HRA is exhausted, you are responsible for 100% of the Remaining Deductible. **Covered Medical Expenses at First Choice Providers are no cost to you once your HRA is exhausted.** Any amounts that you pay for Covered Medical Services at non-First Choice, In-Network providers will accumulate towards your Remaining Deductible until it is met.

Collective Deductible

The Remaining Deductible may be satisfied by applicable expenses incurred by any or all of your covered family Members. This Plan does not have separate Deductibles for individual Members except in the case of Employee-Only coverage.

Overview of Deductible Amounts

Plan Option and Coverage Tier	Deductible Amounts
LSU First Option 1	
<i>Employee Only</i>	
HRA	\$500
Remaining Deductible	\$500
Total Deductible	\$1,000
<i>Employee + Spouse</i>	
HRA	\$750
Remaining Deductible	\$750
Total Deductible	\$1,500
<i>Employee + Child(ren)</i>	
HRA	\$750
Remaining Deductible	\$750
Total Deductible	\$1,500

Family	
HRA	\$1,000
Remaining Deductible	\$1,000
Total Deductible	\$2,000

The following copays apply to the specified services:

Service	Copay
Emergency Room- Copay waived if admitted.	\$150
Gastric Sleeve	\$3,500
Gastric Bypass	\$5,000

The following penalties apply to the specified services:

Service	Penalty
Advanced Imaging-CT/MRI/SPECT if performed in a hospital setting.	\$150
<p>The following facilities can be used without penalty due to lack of First Choice providers in the area: New Orleans: University Medical Center, Touro Infirmary Hospital, Children's Hospital, East Jefferson General Hospital, Touro Imaging Center Shreveport Area: Ochsner LSU Health Shreveport, St. Mary Medical Center Monroe: Ochsner LSU Monroe Alexandria: MR Imaging, Open Air MRI of Central LA, Rapides Regional Medical Center Eunice: Acadian Medical Center Baton Rouge: Baton Rouge General</p>	

HRA and Remaining Deductible for New Hires

For newly hired Employees with an effective date after January 1st, the Deductible will be pro-rated, based on the number of months remaining in the Plan Year (see chart below).

New Hire Table for Option 1						
EFFECTIVE DATE	Employee Only		Employee + Spouse Employee + Child(ren)		Family	
	HRA	Remaining Deductible	HRA	Remaining Deductible	HRA	Remaining Deductible
January 1 st	\$500.00	\$500.00	\$750.00	\$750.00	\$1,000.00	\$1,000.00
February 1 st	\$458.00	\$458.00	\$688.00	\$688.00	\$917.00	\$917.00
March 1 st	\$417.00	\$417.00	\$625.00	\$625.00	\$833.00	\$833.00
April 1 st	\$375.00	\$375.00	\$563.00	\$563.00	\$750.00	\$750.00
May 1 st	\$333.00	\$333.00	\$500.00	\$500.00	\$667.00	\$667.00
June 1 st	\$292.00	\$292.00	\$438.00	\$438.00	\$583.00	\$583.00

July 1 st	\$250.00	\$250.00	\$375.00	\$375.00	\$500.00	\$500.00
August 1 st	\$208.00	\$208.00	\$313.00	\$313.00	\$417.00	\$417.00
September 1 st	\$167.00	\$167.00	\$250.00	\$250.00	\$333.00	\$333.00
October 1 st	\$125.00	\$125.00	\$188.00	\$188.00	\$250.00	\$250.00
November 1 st	\$83.00	\$83.00	\$125.00	\$125.00	\$167.00	\$167.00
December 1 st	\$42.00	\$42.00	\$63.00	\$63.00	\$83.00	\$83.00

HRA and Remaining Deductible for Mid-Year Allowable Changes

If you make an allowable change to your Coverage Tier during the Plan Year (see section entitled “Enrollment”), your Deductible will be prorated, if applicable, based on the number of months remaining in the Plan Year. If you move to a higher Coverage Tier by adding dependent(s), then your current Plan Year HRA and Remaining Deductible will be increased as applicable. If you move to a lower Coverage Tier by removing dependent(s), your current Plan Year HRA will be reduced by no more than the amount remaining in your current Plan Year HRA, and your Remaining Deductible will be reduced by no more than the amount not yet met.

You can keep track of your Deductible online at www.lsu.edu/lsufirst by selecting “My Accounts” and then click “webtpa.com” or by calling the toll-free customer service number 1-855-346-LSU1 .

3. Coinsurance for Covered Medical Expenses

After you have satisfied your Deductible, you enter the Coinsurance component for Covered Medical Services. You pay a percentage of the cost until you have reached the Medical **Out-of-Pocket Maximum** for your Coverage Tier.

Remember: After your current year and roll-over HRA is exhausted, LSU First pays 100% (except for copays and penalties) of Covered Expenses to First Choice Providers. Therefore, you pay nothing for First Choice Providers.

Medical Services In-Network Coinsurance

For In-Network Providers, the maximum Plan liability is the Contracted Reimbursement Rate (“Contract Rate”). The Plan pays 80% and you pay 20% of the Contract Rate for Covered Medical Services. Once you meet your Out-of-Pocket Maximum for the Covered Medical Services for the Plan Year, the Plan pays 100% of the Contract Rate.

Medical Services Out-of-Network Coinsurance

For Out-of-Network Providers, you will be responsible for the following:

- 40% of the Maximum Allowable Charge for Covered Expenses; **and**
- any amount billed by the provider over the Maximum Allowable Charge

In addition, your payments to an Out-of-Network Provider for Covered Services, in excess of the Maximum Allowable Charge, do not accumulate toward your Out-of-Pocket Maximum. **You will still be responsible for amounts above the Maximum Allowable Charge.**

Maximum Medical Out of Pocket

To protect you, LSU First has established the maximum amount you will pay for in-network medical services. Your percentage of Coinsurance for Covered Medical Expenses accumulates toward the Medical Out-of-Pocket Maximum. The Medical Out-of-Pocket Maximum varies based on your Coverage Tier. Your HRA, Your Remaining Deductible, and the Covered Medical Expenses for you and your Dependents contribute towards the Medical Out-of-Pocket Maximum. There is no Medical Out of Pocket Maximum for services provided by Out-of-Network providers.

Pharmacy Coverage:

Non-Specialty Tier 1 Generic Drugs: are paid at 100% by the plan. These include but are not limited to:

- o Diaphragms/Cervical Caps
- o Generic hormonal contraceptives
- o Generic emergency contraceptives
- o Implantable medications
- o Intrauterine contraceptives

Brand Name and Specialty Prescription Drug Coinsurance. Plan members are responsible for 20% of the cost of the drug, up to a cap of \$150 for a 30 day supply and a cap of \$450 for a 90 day supply of Brand Name Tier1 e and/or Specialty prescription drugs. Drugs that are classified as generic specialty medications are subject to the same rules as brand specialty medications.

Any coinsurance payments are included in the Pharmacy Out-of-Pocket Maximum and continue for the duration of the Plan Year or until your Pharmacy Out-of-Pocket Maximum is reached. Once your Pharmacy Out-of-Pocket Maximum is reached, you pay \$0 for covered prescriptions. The Pharmacy Out-of-Pocket Maximums are listed in subsequent pages.

With the exception of drugs identified by the PBM as Brand for Generic drugs, if an equivalent Tier 1 Generic Drug is available and you request a medication in a higher tier, the higher-tier Drug will not be covered. If an equivalent Tier 1Generic Drug is available and your physician requests that the pharmacy not substitute the Tier 1 Generic for the prescribed higher-tier Drug, the higher tier Drug will not be covered. If your physician establishes medical necessity with the Pharmacy Benefits Manager to warrant the higher tier drug, the higher tier Drug will be covered according to the terms of the Plan.

Important Note:

The PBM is the final arbiter of whether a drug is considered Tier 1, Tier 2, Tier 3, or Tier 4. Additionally, the formulary is subject to change. If you fill a prescription for any medication at an Out-of-Network Pharmacy, you will have to pay the entire cost at the time of purchase and then file a claim for reimbursement with the Pharmacy Benefits Manager. Subject to satisfying your applicable Coinsurance, you will be reimbursed by the Plan based on the In-Network contracted rate for a Covered Prescription Drug Expense.

You will be responsible for any difference between the Out-of-Network Pharmacy's price and the Plan's level of reimbursement and that amount, if applicable, does not apply to the Pharmacy Out-of-Pocket maximum.

Medical Expense Out-of-Pocket Maximum

	First Choice Provider	In-Network Provider (Aetna ASA and Verity HealthNet Providers)	Out-of-Network Provider (A non-contracted Provider)
Coinsurance You Pay	\$0	20% of Covered Expenses	40% of Maximum Allowable Charge ² for Covered Expenses plus any amount above the Maximum Allowable Charge ²
LSU First Option 1 Out-of-Pocket Maximum			
<i>Employee Only</i>	Not Applicable ¹	\$4,500	Unlimited ³
<i>Employee + Spouse</i>	Not Applicable ¹	\$6,750	
<i>Employee + Child(ren)</i>	Not Applicable ¹	\$6,750	
<i>Family</i>	Not Applicable ¹	\$9,000 ⁴	

¹ After your HRA is exhausted, LSU pays 100% for First Choice Providers and Non-Specialty Generic Drugs. Therefore, you pay nothing for First Choice Providers and Non-Specialty Generic Drugs.

² Maximum Allowable Charge (also known as Usual and Customary or Reasonable and Customary)

The Out-of-Pocket Maximums listed above include HRA, Deductibles, Covered Medical Expenses/Coinsurance and Covered Prescription Expenses.

For Out-of-Network Providers, LSU will pay 100% of the Maximum Allowable Charge once the Out-of-Pocket Maximum is reached.

³Charges exceeding the Maximum Allowable Charge will be the Member’s responsibility.

⁴ Each individual may meet only \$9000.

PHARMACY		
Coinsurance You Pay	Tier 1 Generic: \$0	Tier 2, Tier 3, Tier 4: 20% cost of drug not to exceed \$150.00 for 30-day supply or \$450 for a 90-day supply.
Pharmacy Out-of Pocket Maximum		
<i>Employee Only</i>		\$4,500
<i>Employee + Spouse</i>		\$6,750
<i>Employee + Child(ren)</i>		\$6,750
<i>Family</i>		\$9,000 ⁴

MEDICAL BENEFITS

Medical Benefits

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge. These medical benefits will be payable as outlined in this Plan. Subject to the Plan's provisions, limitations and Exclusions, the following are covered major medical benefits:

Acupuncture Benefits are available when services are Medically Necessary. Benefits are limited to twelve (12) visits per Benefit Period, when performed by a physician as defined within this document. Treatment must be for a condition covered under the plan. All other subsequent acupuncture visits are not covered.

Advanced Imaging. Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

Allergy Services. Charges related to the treatment of allergies.

Ambulance. Covered Expenses for professional ambulance, including approved available air, road, water, and rail transportation, to a local Hospital, or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient confinement. No benefits are available when a Hospital transports a participant between facilities owned or affiliated with the same entity.

Air Ambulance:

- Emergency Transport. Benefits for Air Ambulance services are available for Participants with an Emergency Medical Condition. The air ambulance service must be specifically requested by police or medical authorities present at the site with the Participant in order for air ambulance services to be covered.

Benefits for air ambulance services are available for or when the Participant is in a location that cannot be reached by ground ambulance or when medically necessary if ground ambulance would not be time effective.

- Non-Emergency Transport. Air ambulance for non-emergency situations require prior authorization from the Utilization Review Manager. If authorization is not obtained prior to services being rendered, the services will not be covered.

Once authorized, it is recommended that the Participant verify the Network participation status of the air ambulance provider in the state or area the point of pick-up occurs, based on the zip code. To locate a Network Provider, log onto www.lsu.edu/lsufirst and click on "Search for Providers." You may also call 1-855-346-LSU1 and a customer service representative can locate a Provider in one of the networks.

Be sure to ask for a provider who is "contracted with" either First Choice, Aetna ASA, or Verity to find a provider in the specific networks. A provider contracted with the Aetna ASA or Verity networks will accept your LSU First Plan, but may not be a part of the First Choice network. You must specify that you are looking for a provider "contracted with" First Choice if you want to avoid Out-of-Pocket expenses.

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

No benefits are available if transportation is provided for a Participant's comfort or convenience.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided.

Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

Attention Deficit / Hyperactivity Disorder. Services for the diagnosis of and treatment for Attention Deficit / Hyperactivity Disorder when rendered or prescribed by a Physician.

Autism. Charges for the screening, diagnosis and treatment of autism spectrum disorder, including Applied Behavior Analysis (ABA) Therapy for treatment of Autism Spectrum Disorder (ASD).

Bariatric Surgery. Bariatric procedures may be available to a member through a limited program managed by HighCare Health. The plan will only cover one surgical procedure per lifetime, Revisions are not covered. Bariatric procedures received outside of the program will NOT be covered by the Plan.

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood.

Breast Milk. Prescription Donor Human Breast Milk Benefits are available for Medically Necessary pasteurized donor human breast milk prescribed for a Dependent infant, until one (1) year of age, undergoing Inpatient care or Outpatient care who is medically or physically unable to receive maternal human milk, participate in breastfeeding, or whose mother is medically or physically unable to produce maternal human milk in sufficient quantities. This coverage is limited to a two-month supply per infant per lifetime and is limited to prescribed donor human breast milk obtained from a member bank of the Human Milk Banking Association of North America or other approved source.

Benefits are subject to the applicable Deductible Amount and Coinsurance shown on the Schedule of Benefits.

Breast Pumps. Breast pumps are covered at 100% of the allowable, subject to applicable federal law. Coverage is limited to the lowest-cost alternative as determined by Plan Medical Management. The Plan covers a manual or standard electric breast pump as Medically Necessary for the initiation or continuation of breastfeeding.

The Plan covers rental of a heavy duty electrical/Hospital grade breast pump up to the purchase price as Medically Necessary for the initiation or continuation of breastfeeding for EITHER of the following indications:

- Direct breastfeeding is not possible because of a separation due to the prolonged or repeat hospitalization of either the infant or the mother.
- The infant has a medical condition or congenital anomaly that prevents effective breastfeeding

Breast reduction when deemed Medically Necessary.

Cataracts. Cataract surgery and one set of lenses (contacts or frame-type) following the surgery.

WebTPA Centers of Excellence Program. When cardiac, orthopedic and spine surgery is recommended, the Plan allows a Covered Person the option to access a nationwide Centers of Excellence network of high quality cardiac, orthopedic and spine surgical providers. The cardiac, orthopedic and spine surgery benefit is only available to those Covered Persons who have primary coverage under the Plan and who have been approved by the appropriate WCOE providers based on a review of the Covered Person's diagnosis and

medical history. The WCOE Program is limited to a select list of cardiac, orthopedic and spine procedures that may be subject to change.

The Plan will pay 100% of your Covered Services when accessing a WCOE Network Provider. Covered expenses include all medical costs incurred under the WCOE surgery benefit as well as transportation, lodging and meals.

Travel-Related Criteria

- The Covered Person must travel at least 50 miles one-way from home to the WCOE Provider
- One (1) companion (18 or older) of his or her choice may accompany the Covered Person.
- Expenses are covered only during the period of time the Covered Person is under the care of a Provider. The pre-operative visit will be the day before surgery and post-operative visits immediately after surgery are included in the WCOE surgery benefit. Once the Covered Person is transitioned from the surgical episode, future claims for services will be handled according to the provisions of the Plan.

Covered Transportation Expenses

- If air travel is required, WebTPA will purchase non-refundable, coach/economy airline tickets. If automobile travel is required, WebTPA will reimburse mileage at the current IRS allowable rate.

Lodging Expenses

- Accommodations for one room that are made by WebTPA at a mid-market chain hotel.

Food and other Miscellaneous Expenses

- \$50 per day for the Covered Person while not admitted to the hospital and \$50 per day for the traveling companion.

If a change in surgery date is requested, the Covered Person will be responsible for the cost associated with the change, including any transportation cancellation fees and/or higher costs.

Contacting the WebTPA Centers of Excellence Program

When you access the WCOE Benefit Program you will be assigned a care concierge who will assist you throughout your episode of care. When surgery has been recommended contact WebTPA: 855-346-LSU1

Chemotherapy. Charges for chemotherapy, including materials and services of technicians.

Chiropractic Care. Chiropractic Services are covered, as shown on the Summary of Benefits, when performed by a chiropractor licensed and practicing within the scope of his license. A licensed chiropractor may make recommendations to personal hygiene and proper nutritional practices for the rehabilitation of a patient and may order such diagnostic tests as are necessary for determining conditions associated with the functional integrity of the spine.

Chiropractic Services are not covered when maintenance level of therapy is attained. A maintenance program consists of activities that preserve the Plan Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

Maintenance therapy is not covered except for periodic visits to reinforce any need for therapy or current therapeutic objectives.

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

Cleft Lip and Cleft Palate Services. The following services for the treatment and correction of Cleft Lip and Cleft Palate:

- Oral and facial surgery, surgical management, and follow-up care.
- Prosthetic treatment, such as obturators, speech appliances, and feeding appliances.
- Orthodontic treatment and management.
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
- Speech language evaluation and therapy
- Audiological assessments and amplification devices.
- Otolaryngology treatment and management.
- Psychological assessment and counseling.
- Genetic assessment and counseling for patient and parents.

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

Cochlear Implants. Charges for cochlear implants for Participants who are certified as deaf or hearing impaired by a Provider.

Contraceptives. The charges for all Food and Drug Administration (FDA) approved contraceptives methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines. **NOTE:** *Oral contraceptives are covered under the Prescription Drug Benefits section.*
Family Planning Services:

- Office Visits, Lab and Radiology Tests and Counseling
- Contraceptives
 - Oral contraceptives
 - Emergency contraceptives
 - Contraceptive services and devices, such as IUDs, Norplant, Depo-Provera injections
- Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)

The following are covered at 100% of the allowable and no need to use your HRA dollars:

- Diaphragms/Cervical Caps
- Tier 1 Generic hormonal contraceptives
- Tier 1 Generic emergency contraceptives
- Implantable medications
- Intrauterine contraceptives

COVID-19 (2019 Novel Coronavirus). Covered Expenses associated with testing for COVID-19 include the following:

- **Diagnostic Tests.** The following items are covered at 100%, Deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Provider's website, or such other amount as may be negotiated by the Provider and Plan.
 - In vitro diagnostic products for the detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
 - That are approved, cleared, or authorized by the FDA;
 - For which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act,

unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;

- That are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
- That are deemed appropriate by the Secretary of Health and Human Services.

Effective January 15, 2022, The Plan's coverage of diagnostic tests for the detection of SARS-CoV-2 or the virus that causes COVID-19 will include Over-the-Counter tests purchased without a prescription. These tests will be covered under the Prescription Drug Plan. Please contact your Pharmacy Benefit Manager for additional information on reimbursement and limitations.

- Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.
- *Qualifying Coronavirus Preventive Services.* The following items are covered at 100%, Deductible waived, and do not require Pre-Certification.
 - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
 - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- *Telehealth and Other Communication-Based Technology Services.* Participants can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Participant believes he or she has COVID-19 symptoms.
- *Requests for Prescription Refills.* When considering whether to cover a greater-than--day-supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

The above benefits are specific to Diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

Dental Services—Accident Only. Charges made for a continuous course of dental treatment started within 90 days, and completed within 24 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

Note: No charge will be covered under this Plan for dental and oral Surgical Procedures involving orthodontic care of teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures.

Diabetic Education. Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

Diabetic Services, ~~subject to the following~~ including:

- Diabetic supplies and insulin
- One-time evaluation and training program for diabetes self-management when Medically Necessary
- Additional diabetes self-management training when Medically Necessary
- One pair of diabetic shoes and inserts per year.

Support and Savings for Those with Diabetes

LSU First can help save you money on your diabetic supplies. Some diabetic supplies (such as test strips, lancets, blood glucose meters, and insulin pumps) may be covered through your medical benefit. If a First Choice provider processes a claim for covered supplies through your medical benefit, you will not pay anything Out-of-Pocket. Once your current year HRA is exhausted, LSU First will cover those supplies 100%.

Please check your directory (or call the phone number on your ID card) for current First Choice providers who may provide you with such services as:

- Free delivery
- Regular reminders
- Certified Diabetes Educators to answer your questions by phone
- Brand name diabetes testing supplies
- Coordination with your doctor to make sure you receive the testing supplies you need to follow your doctor's orders

Please note that insulin and pre-filled insulin pen needles must be processed through your pharmacy benefit and so are subject to your deductible and pharmacy coinsurance. If you have Medicare coverage primary over LSU First, please contact Medicare for instructions on how to obtain diabetic supplies.

Diagnostic Tests; Examinations. Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures.

Dialysis. Charges for dialysis. If member is eligible for dialysis coverage under Medicare, LSU First will only pay secondary to Medicare.

Durable Medical Equipment. Charges for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician for use outside a Hospital or other health care facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a misuse are the Member's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by Plan Medical Management. Durable Medical Equipment includes, but is not limited to the following, except where the primary purpose is for convenience and/or patient comfort (predetermination by Plan Medical Management is required for equipment exceeding \$1000):

- Crutches
- Hospital beds
- Respirators, when determined Medically Necessary by Plan Medical Management
- Wheel Chairs
- Dialysis Machines
- Diabetic Supplies
- Chairs, lifts and standing devices, including seat lifts (mechanical or motorized), patient lifts (mechanical or motorized— manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs
- Bed related items, including mattresses, non-power mattresses, custom mattresses and posturepedic mattresses

Durable Medical Equipment items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase.

Employee Assistance Program (EAP) With your Employee Assistance Program (EAP), now you can use myStrength to help enhance your emotional well-being. It's a new kind of online wellness portal. You can use it to support your mind, body and spirit. Best of all, it's a free part of your program.

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety or substance abuse. Once you get set up with myStrength, you'll log on to a home page created just for you.

With the myStrength application, you can get inspired on the go by getting custom inspiration based on your mood, track your mood over time, upload your own inspiring photos and videos and opt to receive check-in reminders.

myStrength is:

- Clinically proven
- Free and available 24/7
- Easy to use
- Confidential

Easy sign up: Please visit the following website and utilize the login information below:
www.mylifevalues.com

- Username: peaceofmind
- Password: solutions

Foot Disorders. Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care).

Gene-based, Cellular and other Innovative Therapies (GCIT). Covered services include GCIT provided by a physician, hospital or other provider.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. These are “GCIT services.”

KEY TERMS:

Gene. A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular. Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic. Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
 - Luxturna® (Voretigene neparvovec)
 - Zolgensma® (Onasemnogene abeparvovec-xioi)
 - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
 - Antisense. An example is Spinraza.
 - siRNA.
 - mRNA.
 - microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies The Plan designates facilities to provide GCIT services or procedures. GCIT physicians, hospitals and other providers are GCIT-designated facilities/providers for Aetna and CVS Health.

Important note:

Participants must receive GCIT covered services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it's important that the Participant contact the Plan so we can help you determine if there are other facilities that may meet your needs. If you do not receive your GCIT services at the facility/provider designated, they will not be covered services.

Genetic Counseling or Testing. Subject to the following (pre-authorization required):

The coverage of genetic testing requires pre-certification review. During this review, a licensed physician will review the request for testing and supporting documentation provided by the physician. Consideration of coverage will be based on the CDC Tier Category as follows: Items classified and meeting the requirements of CDC Tier I would be approved for medical necessity after review by our internal medical team. Items classified as meeting the requirements of CDC Tier II would be evaluated for Medical Necessity and appropriateness by our internal physician. Items classified as Tier III would not be covered as Medically Necessary in accordance with CDC recommendations.

Genetic counseling is covered if a person is undergoing approved genetic testing or if a person has an inherited disease and is a potential candidate for genetic testing.

Glaucoma. Treatment of glaucoma.

Habilitative Services. Habilitative services include, but are not limited to, physical therapy, occupational therapy and speech therapy for the treatment of a person with a congenital or genetic birth defect. These services include:

1. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist for a congenital or genetic birth defect, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care, or at a free-standing outpatient facility. Limited to a combined total of 60 days per Plan Year for Physical and Occupational therapies.
2. **Physical Therapy.** Treatment or services rendered by a physical therapist for a congenital or genetic birth defect, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care, or at a free-standing duly licensed outpatient therapy facility. Limited to a combined total of 60 days per Plan Year for Physical and Occupational therapies.
3. **Speech Therapy.** Speech therapy, by a Physician or qualified speech therapist, when needed due to cerebral palsy, autism, or a congenital or genetic birth defect. Limited to a separate total of 60 days per Plan Year for Speech Therapy. These maximums do not apply to Medically Necessary therapies for the treatment of autism.

Hearing Aids. Charges for hearing aids prescribed by a physician, which includes examinations for the prescription, fitting, and/or repair of hearing aids.

- Hearing aids prescribed for minor Children under 18 are limited to one hearing aid per impaired ear every 36 months, whether external or implantable or any related expenses. Coverage is limited to the lowest-cost alternative as determined by Plan Medical Management.
- Hearing aids prescribed for Participants over age 18 are limited to a maximum of \$2,400.00 per hearing aid per impaired ear every 36 months, whether external or implantable or any related expenses.

Hearing aids prescribed for minor Children and adults will be covered if the hearing aids are fitted and dispensed by a licensed audiologist following medical clearance by a Physician or an audiological evaluation medically appropriate to the age of the Child, if applicable.

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an illness or injury when hospital or skilled nursing facility confinement would otherwise be required. Coverage is limited to 60 visits in a calendar year by a home healthcare professional. Additional visits may be approved based upon medical necessity. The diagnosis, care, and treatment must be certified by the attending physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.
4. Physician calls in the office, home, clinic or outpatient department.
5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care. **NOTE:** Home infusion therapy does not apply to the home health care maximum.
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.
7. Services of a nutritionist

NOTE: Transportation services are not covered under this benefit.

Home Infusion Therapy, subject to the following:

When ordered by a physician, including:

- Solutions and pharmaceutical additives
- Pharmacy compounding and dispensing services
- Ancillary medical supplies
- Nursing services to:
 - o Train you or your caregiver
 - o Monitor the home infusion therapy
 - o Provide emergency care
 - o Handle collection, analysis and reporting of lab tests to monitor response to home infusion therapy, enteral feedings
 - o Provide other eligible home health supplies and services during home infusion therapy

Hospice Care. Charges relating to Hospice Care, provided the Participant has a life expectancy of six months or less. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an injury or illness.
3. Medical supplies, Drugs and medicines prescribed by the attending physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.

The Hospice Care program must be renewed in writing by the attending physician every 30 days. Hospice Care ceases if the terminal illness enters remission.

Hospital. Charges made by a Hospital for:

1. Inpatient Treatment
 - a. Daily semi private Room and Board charges.
 - b. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
 - c. General nursing services.
 - d. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.
2. Outpatient Treatment
 - a. Emergency room.
 - b. Treatment for chronic conditions.
 - c. Physical therapy treatments.
 - d. Hemodialysis.
 - e. X ray, laboratory and linear therapy.

Warning: The fact that a Hospital or other facility is a First Choice or In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based Physicians or Providers may not be Contracted Health Care Providers.

If the medical benefits under this Plan cease for you or your Dependent, and you or your Dependent is Confined in a Hospital on that date, medical benefits will be paid for Covered Expenses incurred in connection with that Hospital confinement. However, no benefits will be paid after the earliest of: The date you exceed the maximum benefit, if any, shown in the Schedule;

- The date you are covered for medical benefits under another group plan;
- The date you or your Dependent is no longer Hospital Confined; or
- 12 months from the date your medical benefits cease.

The terms of this medical benefits extension will not apply to a Child born as a result of a pregnancy which exists when your medical benefits cease, or your Dependent's Medical Benefits cease.

Impregnation and Infertility Treatment. Infertility Treatment Services are provided as related to diagnosis of infertility. Once a condition of infertility has been diagnosed, treatment of infertility is covered, subject to a lifetime maximum of \$25,000 in Medical Plan payments and \$10,000 in Prescription Plan payments. The following charges related to Impregnation and Infertility Treatment are covered, whether or not such procedure is successful:

- Surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests
- Sperm washing or preparation; and
- Diagnostic evaluations post diagnosis.
- Infertility medications for the following indications (lifetime maximum for infertility medications is \$10,000)
- Treatment for infertility, endometriosis, uterine leiomyomata (fibroids)

Mammography. Preventive and diagnostic mammograms. 3D mammograms are not covered under the preventive benefit.

Mastectomy. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the Mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Participant and his or her attending Physician.

Medical Foods. Medical foods are considered a covered charge if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except formula when needed for the treatment of PKU, when deemed medically necessary.

Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.

Mental Health and Substance Abuse Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.

Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services. Covered services include, but are not limited to outpatient treatment of conditions such as:

- Anxiety or depression which interfere with daily functioning
- Emotional adjustment or concerns related to chronic conditions, such as psychosis or depression
- Emotional reactions associated with marital problems or divorce
- Child/adolescent problems of conduct or poor impulse control
- Affective disorders
- Suicidal or homicidal threats or acts
- Eating disorders
- Acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention)
- Outpatient testing and assessment

Substance Use Disorder Treatment – HighCare Health Care Coordination is recommended for Covered Persons receiving Substance Abuse benefits to assist in receiving all available benefits and a positive outcome. Through participation in the free Care Coordination program, members will be assigned to a Behavioral Health Professional who can assist with questions or concerns related to the member's health via phone or email to continue to monitor the medical needs of the members. Our services include, but are not limited to, disease and medication education, coordinating community resources, assisting members in navigating the healthcare system, and empowering members to achieve long-term behavior modification.

Midwife Services. Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

Newborn Care. Hospital and Physician nursery care for newborns who are natural Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:

- a. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
- b. Circumcision.

NOTE: *The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.*

Nicotine Addiction. For Covered Persons who use tobacco products, up to two tobacco cessation attempts will be covered per Calendar Year under the Medical Plan.

All Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization will be covered under the Prescription Drug Benefit Plan.

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Nutritional Supplements. Low Protein Food Products especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low Protein Food Products do not include natural foods that are naturally low in protein.

Medically Necessary Low Protein Food Products are covered for the treatment of only the following inherited metabolic diseases:

- Glutaric Acidemia
- Isovaleric Acidemia (IVA)
- Maple Syrup Urine Disease (MSUD)
- Methylmalonic Acidemia (MMA)
- Phenylketonuria (PKU)
- Propionic Acidemia
- Tyrosinemia
- Urea Cycle Defects

Nutritionists. Charges made for nutritional evaluation and counseling are covered only when required to treat a medical condition when diet is part of the medical management of a documented organic disease.

Oral Surgery. Oral surgery in relation to the bone, including tumors, cysts and growths not related to the teeth, and extraction of soft tissue impacted teeth by a Physician or Dentist.

- Removal of bony impacted wisdom teeth is covered.
- Inpatient and outpatient Hospital and anesthesia expenses related to dental work if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition
- For care/treatment rendered as a direct result of radiation therapy to the oral cavity/mucosa, including dental extraction and disposable radiation mouth guard secondary to such radiation therapy.

Oxygen and other gasses.

Pathology Services. Charges for pathology services.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

Pregnancy Expenses. Expenses attributable to a Pregnancy. Pregnancy expenses of Dependent Children are not covered. Benefits for Pregnancy expenses are paid the same as any other Illness. **NOTE:**

Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

Benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an illness.

Preventive Care. Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See the following websites for more details:

[https://www.healthcare.gov/coverage/preventive-care-benefits/;](https://www.healthcare.gov/coverage/preventive-care-benefits/)

[https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;](https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)

[https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;](https://www.cdc.gov/vaccines/hcp/acip-recs/index.html)

[https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)

[https://www.hrsa.gov/womensguidelines/.](https://www.hrsa.gov/womensguidelines/)

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: <http://www.hrsa.gov/womensguidelines/> or at the websites listed above.

Prosthetics, Orthotics, Supplies and Surgical Dressings. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Replacement no more than once every 24 months for Members 19 years of age and older. Replacement no more than once every 12 months for Members 18 years of age and under. See the list of non-covered orthoses in the Medical Exclusions below.

Orthoses and Orthotic Devices (includes splints and braces) but excluding orthopedic shoes and other supportive devices for the feet. Coverage is provided for preparation, fitting and basic additions (such as bars and joints) for the following when found to be Medically Necessary:

- Rigid and semi-rigid custom fabricated orthoses
- Semi-rigid prefabricated and flexible orthoses
- Rigid prefabricated orthoses

Custom foot orthoses are covered as follows:

- For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease)
- When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace
- When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Illness or congenital defect
- For persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

Radiation Therapy. Charges for radiation therapy and treatment.

Reconstructive Surgery. Charges made for reconstructive surgery limited to the following:

- Reconstructive surgery following a covered mastectomy;
- Surgery to repair a defect caused by an accidental injury resulting in a functional impairment;
- Reconstructive surgery related to or following surgery that was needed due to an injury, sickness, or other disease of that part of the body; and
- Reconstructive surgery to repair a Dependent Child's congenital or developmental defect.

Rehabilitative Services. Rehabilitative therapy techniques help restore skill and function after an injury, illness, or surgery. It may also help treat and manage the symptoms of a health condition that impacts the patient's quality of life. Services must be provided in the most medically appropriate setting. Services are not covered if they are custodial, instructional, or educational. Refer to the exclusions for additional information.

1. **Cardiac Therapy.** Charges for cardiac therapy to reduce the risk of complications in people with heart conditions. It typically involves exercises, education about topics such as the diet, and stress management techniques.
2. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing outpatient facility. Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Illness. Limited to a combined total of 60 days per Plan Year for Physical and Occupational therapies. These maximums do not apply to Medically Necessary therapies for the treatment of autism.
3. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed outpatient therapy facility. Limited to a combined total of 60 days per Plan Year for Physical and Occupational therapies. These maximums do not apply to Medically Necessary therapies for the treatment of autism.
4. **Respiration Therapy.** Respiration therapy services, exercises and treatments that help patients recover lung function, such as after surgery or with a diagnosed diseased lung condition when rendered in accordance with a Physician's written treatment plan and provided by a registered or licensed therapist when needed to correct a functional disorder due to an illness or injury.
5. **Speech Therapy.** Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech therapist, when needed for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly, or underlying medical condition. Limited to a separate total of 60 days per Plan Year for Speech Therapy. This maximum does not apply to Medically Necessary therapies for the treatment of autism.
6. **Vision Therapy.** An attempt to develop or improve visual skills and abilities; improve visual comfort, ease, and efficiency; and change visual processing or interpretation of visual information. Covered only in the case of diabetics.

Routine Eye Exam - Limit 1 exam annually payable under the Preventive Care/Wellness benefit starting at age 16. Includes Digital Retinal Imaging only with a confirmed prior diagnosis of diabetes. Please have your healthcare provider contact Medical Management for confirmation of diagnosis prior to incurring these charges.

Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the ACA, provided:

1. The clinical trial is approved by any of the following:
 - a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
 - b. The National Institute of Health.
 - c. The U.S. Food and Drug Administration.
 - d. The U.S. Department of Defense.
 - e. The U.S. Department of Veterans Affairs.
 - f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
2. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Covered Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Legally Required Expenses

Notwithstanding the Plan exclusions, with respect to Investigational or Experimental items or services or costs associated with clinical trials, such items or services required to be covered or paid for by LA. R.S. 22:1044 or La. R.S. 22:999 will be covered by the Plan, subject to all other applicable exclusions or limitations. Generally, such items or services involve clinical trials for cancer, if the statutory requirements are met, and drugs prescribed for the treatment of cancer, if such drug is recognized for treatment of the covered indication in a standard reference compendium or in substantially accepted peer-reviewed medical literature. Your Human Resource Management Department can provide you with a copy of the statutory provisions referenced above. Please contact the Claim Administrator to determine whether a particular item or service is covered under these provisions of the law. Items which must be covered under the above statutes may be generally described as follows: Patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer except any applicable copayment, Deductible, or coinsurance amounts. Such costs shall include coverage for costs incurred for health related services not otherwise required under La. R.S. 22:999.

Costs of investigational treatments and costs of associated protocol related patient care shall be covered if all of the following criteria are met:

1. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
2. The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
3. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
 - a. one of the United States National Institutes of Health (NIH);
 - b. a cooperative group funded by one of the NIH;
 - c. the FDA in the form of an investigational new drug application;
 - d. the United States Department of Veterans Affairs;
 - e. the United States Department of Defense;
 - f. a federally funded general clinical research center;
 - g. the Coalition of National Cancer Cooperative Groups.
4. The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
5. The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
6. There is no clearly superior, non-investigational approach.
7. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non- investigational alternative.
8. The patient has signed an institutional review board approved consent form.

A drug prescribed for the treatment of cancer, but not approved for such use by the FDA, but which is recognized for treatment of the covered indication in a standard reference compendium or in substantially accepted peer-reviewed literature will be covered. Coverage for a drug covered by this provision shall also include all Medically Necessary services associated with the administration of the drug. This provision shall not be construed to require coverage for a drug if the FDA has determined its use to be contraindicated for the patient's condition. This provision shall not apply to drugs or services which are furnished in a research trial, if the sponsor of the research trial furnished the drugs or services without charge to participants in the trial

Second Surgical Opinions. Charges for second surgical opinions.

Sexual Dysfunction. Limited to sexual counseling, or therapy, implants and hormonal therapy for dysfunction due to organic disease.

Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facility. Charges made by a Skilled Nursing Facility, rehabilitation Hospital, sub-acute facility or a convalescent care facility, up to the limits set forth below, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Participant is confined.

Plan Year Maximum: Limited to total of 90 days per Plan Year regardless of the Provider's network status
The Plan pays while the patient is confined as a bed patient in a as long as:

- 24-hour-a-day nursing care is necessary for recuperation from the Injury or Illness; and
- The care is ordered and approved by a physician and is not custodial care; and
- Such confinement takes the place of a Hospital confinement or immediately follows a Hospital confinement for the same illness.

Covered Expenses include the facility's charge for a semiprivate room and all other eligible services and supplies provided by the facility when the patient is entitled to room and board allowance.

Sterilization for Men. Charges for male sterilization procedures. Benefits for all Food and Drug Administration (FDA) approved charges related to sterilization procedures for women are covered under Preventive Care, to the extent required by the Affordable Care Act (ACA).

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

1. Multiple procedures adding significant time or complexity will be allowed at:
 - a. One hundred percent (100%) of the Maximum Allowable Charge for the first or major procedure.
 - b. Fifty percent (50%) of the Maximum Allowable Charge for the secondary and subsequent procedures.
 - c. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of the Maximum Allowable Charge for the major procedure, and fifty percent (50%) of the Maximum Allowable Charge for the secondary or lesser procedure.
2. The Maximum Allowable Charge for services rendered by an assistant surgeon will be limited to twenty percent (20%) of the Maximum Allowable Charge identified for the surgeon's service.
3. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session.

Surgical Treatment of Jaw. Surgical treatment of Illness, Injuries, fractures and dislocations of the jaw by a Physician or Dentist.

Telehealth. Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided for an established patient via audio or video communications. Covered Expenses for Behavioral Health services will include the initial visit.

Temporomandibular Joint Disorder. Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment. Covered based on Medical Necessity. Orthodontic treatment is excluded. Appliances are covered when deemed Medically Necessary by Plan Medical Management.

Transplants. Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

1. Bone marrow.
2. Heart.
3. Lung.
4. Heart and lung.
5. Liver.

6. Pancreas.
7. Kidney.
8. Cornea.
9. Intestine which includes small bowel, liver or multiple viscera

In addition, the Plan will cover any other transplant that is not Experimental.

Coverage is limited to two (2) transplant procedures for the same condition per person. All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.

Recipient Benefits

Covered Expenses will be considered the same as any other Illness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

1. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part.
2. Services and supplies furnished by a Provider.
3. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described herein will be covered. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

When both the person donating the organ and the person receiving the organ are Participants, each will receive benefits under the Plan.

Donor Benefits

The Plan covers donation-related services for actual or potential donors, whether or not they are Participants, as long as the transplant recipient is a Participant. The Plan will cover these costs, provided such costs are not covered in whole or in part by any other source other than the donor's family or estate. This includes, but is not limited to, other insurance, including self-funded medical plans, grants, foundations, and government programs. If a Participant is donating the organ to a person who is not a Participant under this Plan, benefits are not available under this Plan.

Travel Expenses

Travel expenses for the person receiving the transplant are covered, up to \$10,000 per transplant, and include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); *mileage is reimbursed at the IRS rate for medical transportation*, lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 50 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Urgent Care Services. Urgent Care Services for Out-of-Network Providers are paid at 60% of Maximum Allowable Charge.

Virtual colonoscopy, subject to the following: When performed in connection with diagnostic testing only.

Wigs. Charges associated with the initial purchase of a wig after chemotherapy, radiation therapy or alopecia areata. Lifetime limit of 2 wigs.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Abortion. Incurred directly or indirectly as the result of an abortion except when the life of the mother is endangered by the continued Pregnancy, for medical complications that arise from an abortion, or the Pregnancy is the result of rape or incest.

Acupuncture when used to provide treatment for a condition or service that is excluded from coverage under this Benefit plan.

Adoption or surrogate expenses

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, dry needling, massage, and thermography, including drugs.

Charges for **artificial organs or systems** used to assist or replace a natural body organ (such as an artificial heart) and any related services or supplies. Artificial support machines while awaiting a human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are covered.

Augmentative communications devices such as keyboards or voice synthesizers in the case of speech impairments

Biofeedback. For biofeedback.

Biomechanical evaluation, range of motion measurement and reports, and negative mold foot impression

Charges for the treatment of **compulsive gambling**

Dental Care. For normal dental care benefits, including any dental, gum treatments, x-rays, or oral surgery, including hospitalizations and anesthesia. The only exceptions to this are for the following:

- Transplant preparation.
- Initiation of immunosuppressives.
- The direct treatment of acute traumatic Injury, cancer or Cleft Palate.
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Detoxification. Treatment solely for detoxification or primarily for maintenance care. Such care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the effects of a specific drinking or drug episode. Maintenance care consists of the providing of an alcohol-free or drug-free environment.

Developmental disorders (except Autism Spectrum Disorder, as set forth in La. R.S. 22:1050 G. (3)), including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders, unless there is evidence of an underlying medical condition, or a congenital or genetic birth defect.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Examinations. Any health examination required by any law of a government to secure insurance or school admissions or professional or other licenses, except as required under applicable federal law.

Charges for or related to **fetal tissue transplants**.

Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

Full body scans, EBCT (heart scans), except when prescribed for diagnostic rather than preventive or wellness purposes.

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness. **NOTE:** *This Exclusion does not apply to hair pieces and wigs that are covered under the Plan for patients who are undergoing chemotherapy.*

Hypnosis. Related to the use of hypnosis.

Immunizations. For immunizations and vaccinations for the purpose of travel outside of the United States.

Infertility services when the infertility is caused by or related to voluntary sterilization, or for dependents other than a spouse.

Liposuction

Long Term Care. Long term care for custodial or maintenance purposes.

Membership and/or concierge fees that allow Covered Persons access to Physicians for Covered Services.

Non-medical counseling or training services, or services of the clergy, including marriage counseling.

The Mental Health and Substance Use Disorder Benefits exclude the following:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
- Developmental disorders (except Autism Spectrum Disorder, as set forth in La. R.S. 22:1050 G. (3)), including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders, unless there is evidence of an underlying medical condition
- Counseling for activities of an educational nature
- Counseling for borderline intellectual functioning
- Counseling for occupational problems
- Counseling related to consciousness raising
- Vocational or religious counseling
- I.Q. testing
- Custodial care, including but not limited to geriatric day care
- Psychological testing on Children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline

Obesity. Related to the care and treatment of obesity, weight loss or dietary control, unless related to morbid obesity (which is the lesser of 100 pounds over normal weight or twice normal weight). Specifically excluded, even if related to morbid obesity, are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. This Exclusion

does not apply to obesity screening and counseling that are covered under the Preventive Care benefit, or as noted through the plan's bariatric program managed by HighCare Health Care Coordination.

Organ Transplants. Related to donation of a human organ or tissue, artificial or non-human organs, except as specifically provided.

Orthopedic Shoes. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

The following are specifically excluded **orthoses and orthotic devices**:

- Prefabricated foot orthoses;
- Cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- Copes scoliosis braces
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Arch supports;
- Foot orthotics or orthopedic shoes not prescribed by a medical doctor, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a Medically Necessary condition.
- Orthoses primarily used for cosmetic rather than functional reasons; and
- Orthoses primarily for improved athletic performance or sports participation.

Osseous Surgery. For osseous surgery related to teeth.

Personal Convenience Items. For equipment that does not meet the definition of Durable Medical Equipment or for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a physician, including humidifiers and exercise equipment, whether or not recommended by a Physician.

Phototherapy devices for Seasonal Affective Disorder

Physical conditioning programs such as athletic training, body building, exercise, fitness, flexibility and diversion or general motivation.

Physician Self-Treatment or Treatment of Immediate Family Members. Physicians cannot treat themselves or members of their immediate families.

Expenses for **precautionary tests** solely rendered to determine if a Covered Person contracted a disease while traveling outside of the United States

Pregnancy of a Dependent Child. Incurred by an eligible Dependent Child, including, but not limited to, pre-natal, delivery and post-natal care, treatment of miscarriage and complications due to Pregnancy. Maternity is only covered for the employee or the spouse of an employee.

NOTE: Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.

Private Duty Nursing. Private duty nursing.

External Prosthetic Appliances and Devices excludes the following:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices
- Myoelectric prostheses peripheral nerve stimulators

Recreational or educational therapy or other forms of non-medical self-care or self-help training including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related services or diagnostic testing

Short-term **Rehabilitative Therapy and Chiropractic Care** services that are not covered include but are not limited to:

- Sensory integration therapy,
- Group therapy other than for autism;
- Treatment of dyslexia;
- Behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder.
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status
- Chiropractic Care Services excludes the following:
 - Services of a chiropractor which are not within his scope of practice, as defined by state law.
 - Charges for care not provided in an office setting.
- Vitamin therapy

Repair of Purchased Equipment. For maintenance and repairs needed due to misuse or abuse are not covered.

Replacement Braces. For replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

Respite care - the provision of short-term accommodation in a facility outside the home, except as provided in the hospice benefit. This provides temporary relief to those who are caring for family members, who might otherwise require permanent placement in a facility outside the home.

Routine Patient Costs for Participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Routine Physical Examinations. For routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided elsewhere in this Plan.

Sales tax (applicable to Medical Plan only, not to Prescription Drug Benefits)

Scar or tattoo removal or revision.

Services for, or related to, **systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy** determined to be not Medically Necessary

Sex Assignment/Reassignment. Related to a sex change operation, including but not limited to:

- Psychotherapy or counseling
- Pre- and Post-Surgical Hormones
- Sex Reassignment Surgeries

Sexual Dysfunction. For any treatment of a sexual dysfunction, including but not limited to sexual therapy, implants, and hormonal therapy, except of dysfunction due to organic disease, unless otherwise specified by the Plan. Excludes penile and testicular prostheses. Care, treatment, Services, and supplies in connection with treatment for impotence, unless the treatment is related to prostate cancer.

Skin abrasion for treatment of acne.

Snoring. Medical or surgical treatment for snoring in the absence of obstructive sleep apnea. Including but not limited to oral appliances or laser-assisted uvulopalatoplasty (LAUP).

Sterilization Reversal. For sterilization procedure reversal.

Telehealth. Telephone calls, video communication, text messaging, e-mail messaging, or instant messaging or patient portal communications between the Plan Participant and Provider unless specifically stated as covered under the Telehealth Services Benefit for services billed with Telehealth codes not suitable for the setting in which the services are provided.

Travel. For travel, whether or not recommended by a Physician, unless otherwise deemed eligible by the Plan Administrator or his designee's approval, or as specified as covered in the Organ Transplant or Centers of Excellence sections.

Travel and/or lodging expenses of a physician. Travel and/or lodging expenses of a physician, unless otherwise deemed eligible by the Plan Administrator or his designee's approval.

Ventilator-dependent communication services while confined in a Hospital or other medical facility

Vision Care. Expenses for the following:

1. For eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).
2. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.
3. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

Vitamins. For vitamins.

Vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs

Wig accessories such as: Wig caps, wig stands, brushes, sweat liners, toupee clips, adhesives, shampoos, conditioners, sprays, fresheners, mousses, gels, detanglers, wig tape, wig restorer, etc.

Work related Physical Examinations.

Work related immunizations.

UTILIZATION MANAGEMENT

“Utilization Management” consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. The scope of the program includes Hospital admission pre-certification, continued stay review, length of stay determination, discharge planning, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. In order to maximize Plan reimbursements, please read the following provisions carefully.

Services that Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

Inpatient Admissions

All inpatient admissions require pre-cert, except for maternity if less than 48 hours vaginal and 96 hours C-section

- Acute Care Hospital. Maternity only after 48 hours vaginal/96 hours C-section
- Long Term Acute Care (LTAC)
- Acute Physical Rehab
- Skilled Nursing Facility
- Acute Behavioral Health/Substance Abuse.
- Residential Treatment (RTC).

Transplants (excluding cornea)

- Evaluation
- Listing

Medications

- Injectables billed under the medical plan over \$1,000 per dose
- All Blood Clotting Factors

Medical Foods

- Low Protein Food Products are covered for the treatment of specific inherited metabolic diseases

Outpatient Services

Home services

- Home Health Care
- Home Infusion Services

Imaging and Diagnostic

- CT Scan
- MRI
- PET Scan
- SPECT San/Nuclear Imaging
- Genetic Testing

Durable Medical Equipment – hearing aids do not require pre-cert

- DME over \$1,000 – Pre-cert is waived for CPAP if it is one that has to be replaced due to recall
- Custom Prosthetics and Orthotics

Cancer Treatment

- Radiation therapy
- Proton beam therapy
- Chemotherapy

Therapies

- Physical therapy
- Occupational therapy
- Speech therapy
- Cardiac rehab

- Applied Behavioral Analysis (ABA) therapy
- Hyperbaric Oxygen Therapy
- Acupuncture

Chiropractic – must be referred from MD/if Chiropractor using PT-based treatment codes, requires precert as PT visits would and counts toward that benefit maximum

Behavioral Health and Substance Abuse

- Partial Hospitalization Program (PHP_
- Intensive Outpatient Program (IOP)
- Transcranial Magnetic Stimulation
- Neuropsychological Testing
- Methadone Treatment

Outpatient Procedures

• **Musculoskeletal**

- Autologous chondrocyte implantation (ACI) – CPT Codes: 27416
- Spine surgeries
- Osteochondral allograft (knee) – CPT Codes: 27415
- Arthroplasty (joint replacement), any joint
- Arthroscopic hip surgery

• **Ear, Nose, and Throat**

- Cochlear Implant
- Endoscopic sinus surgeries
- Uvulopalatopharyngoplasty – CPT Code: 42145

• **Cardiac/Venous**

- Ventricular Assistive Devices – CPT Code: 33995
- Varicose vein treatment (excluding stab phlebectomy)

• **Genitourinary**

- Bladder Sling
- Hysterectomies

• **Obesity Surgery** – Only covered for members enrolled in the Bariatric Pilot Program with special guidelines

• **Pain Management Procedure – Musculoskeletal and Nervous System**

- Cervical epidural
- Lumbar epidural steroid
- Stellate Ganglion Block – CPT Code: 64510
- Epidural Blood Patch
- Nerve stimulator insertion
- Nerve Blocks
- Epidural steroid injections
- Facet Joint Injections
- Facet Neurotomy/Radiofrequency Ablation
- Sacroiliac Joint Injections
- Kyphoplasty/Vertebroplasty - CPT Codes: 22510, 22511, 22512, 22513, 22514, 22515, 20225, 22310, 22315, 22325, 22327

• **Reconstructive Surgery – Must be medically necessary, non-cosmetic, and not related to gender reassignment surgery (not a covered benefit):**

- Blepharoplasty/Ptosis repair
- Breast surgery/reconstruction
- Rhinoplasty or septoplasty
- Skin grafts/flaps and tissue grafts

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain Pre-Certification if there is a need to have a longer stay.

Pre-Certification does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Pre-Certification Procedures and Contact Information

The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll free number, which is 1-855-346-LSU1. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan may require notice after the Participant's receipt of treatment, once the Participant is able to so provide notice and/or the treating Provider is able to provide notice. Such a claim shall then be deemed to be a Post-service Claim.

Non-Emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the provision entitled "Services that Require Pre-Certification," the service may not be covered.

The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

NOTE: If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims

section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.

Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Participant or their attending Physician may not be deemed to be Medically Necessary or within Maximum Allowable Charge limitations, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary and otherwise covered course of treatment, subject to the Maximum Allowable Charge, been pursued.

Pre-Admission Testing

If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within seven days prior to such Hospital admission will be paid, 100% after the HRA, at 100% of the Maximum Allowable Charge, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

Second Surgical Opinion

If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy.
2. Bunionectomy.
3. Cataract removal.
4. Coronary Bypass.
5. Cholecystectomy (removal of gallbladder).
6. Dilation and curettage.
7. Hammer Toe repair.
8. Hemorrhoidectomy.
9. Herniorrhaphy.
10. Hysterectomy.
11. Laminectomy (removal of spinal disc).
12. Mastectomy.
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach).
14. Nasal surgery (repair of deviated nasal septum, bone or cartilage).
15. Prostatectomy (removal of all or part of prostate).
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome).

17. Tonsillectomy.
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay regular benefits for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

Case Management

Case management is a preemptive coordination of a Participant's care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

Care Coordination

HighCare Health's Care Coordination program uses a risk stratified, proactive, integrated approach with disease management incorporated. We provide evidence-based, member centered education and identify available resources to improve the member's quality of life. The focus is on coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant and includes:

- Support of the physician or practitioner/member relationship with a plan of care
- Emphasis on the prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Focus on (but not limited to) 9 core chronic conditions: Heart Disease, Diabetes, Heart Failure, High Blood Pressure, Mental Health, Chronic Obstructive Pulmonary Disease, Smoking Cessation, Kidney Disease, and Asthma.

Care Coordination facilitates the communication and collaboration between care teams, patients, and their families to keep patients engaged in their care. It approaches care from a whole-person standpoint by addressing various components of health such as physical, mental, environmental, and social needs.

Continuation of Care

If, in the event of a high-risk pregnancy or past the twenty-fourth week of pregnancy or diagnosis of a life threatening illness for which death is probable, the contract with a contracted health care provider is terminated, the provisions of La. R.S. 22:1005, "Continuity of Health Care Services" may be applicable. The contracted health care provider must notify the Plan of applicable Members who have begun a course of treatment prior to the effective date of the contract termination. Thereafter, the Plan shall continue payment of the Contract Rate to the provider on the same basis that was in effect prior to the termination of the contract as follows:

- High-risk Pregnancy or post twenty-fourth week of pregnancy. Through delivery and postpartum care related to the pregnancy and delivery.
- Life threatening illness. For a period of 120 days following termination of the contract.

For more information on how to qualify please call toll-free 1-855-346-LSU1 and select the Medical Management option.

PRESCRIPTION DRUG BENEFITS

Participating pharmacies (“Participating Pharmacies”) have contracted with the Plan to charge Participants reduced fees for covered Drugs. The Pharmacy Benefits Manager (PBM) is the administrator of the prescription drug plan.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.).

Your pharmacy benefit is designed to cover medications that require a prescription for most diseases, including short term illness such as an ear infection, as well as long term diseases, such as high blood pressure. You will receive maximum value from your pharmacy benefit if you bring your prescription and Plan ID card to an In-Network pharmacy.

Certain medications may require prior authorization from the PBM.

The Plan encourages the use of Tier 1 Generic Drugs. If a Tier 1 Generic Drug is available and you select the Tier 2 or Tier 3 Brand Name equivalent, you must pay the full cost of the Brand Name Drug. This does not apply to certain Brand for Generic medications as identified by the PBM.

Compounded drugs are medications that are formulated by the pharmacist. Oftentimes, pharmacies preparing compounded medications do not accept insurance. In those circumstances, you will have to pay the cost of the compounded medication at the time of service and submit a reimbursement form to the Pharmacy Benefit Manager. If the compounded medication is not FDA approved, you will not be reimbursed. All compounded prescriptions over a cost of \$250. require prior authorization

Shingles and Seasonal Vaccinations Administered “in-pharmacy” at PBM Participating Pharmacies
Seasonal influenza and pneumonia as well as shingles vaccinations are Covered Services under the Plan. In addition, Seasonal and Shingles Vaccinations are covered under your Preventive Care Benefit and the medical portion of the Plan, subject to certain limitations (see above). Members may elect to receive seasonal vaccinations “in-pharmacy” at participating pharmacies. Members will not pay anything Out-of-Pocket for Seasonal Vaccines *provided* the vaccinations are received at a Participating Pharmacy and in accordance with the Preventive Care/Wellness benefit.

If you do not have your Plan ID card with you when you fill your prescription, or if you choose to use an Out-of-Network pharmacy, you will need to pay for your prescription up front and file a claim for reimbursement. In either case, you will be reimbursed only the amount that the Plan would have paid at an In-Network pharmacy with a Plan ID card presented.

Covered Expenses

The following are covered under the Plan. Specific limitations, exclusions and maximums may apply such as Prior Authorization, Step-therapy or quantity restrictions.

Acne Control. Drugs that help manage the severity and frequency of acne outbreaks that cannot be purchased over-the-counter.

Bee Sting Kits. Charges for EPI PEN and Ana Kit.

Compounded Prescriptions. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. All compounded prescriptions over a cost of \$250. require prior authorization

Contraceptives. All Food and Drug Administration (FDA)-approved contraceptives Drugs, in accordance with the Health Resources and Services Administration (HRSA) guidelines.

Diabetes. Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over-the-counter, and glucose test strips, when prescribed by a Physician.

Fertility Agents. Charges for fertility agents up to a lifetime maximum of \$10,000.

Growth Hormones. Charges for growth hormones.

Injectables. A charge for injectable medication.

Legend Drugs.

1. Class V Drugs.
2. Diabetic Supplies.
3. Pre-natal vitamins.

Medical Devices and Supplies. Charges for legend and over the counter medical devices and supplies.

Migraine Injection. Charges for migraine auto-injectors.

Required by Law. All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below.

Smoking Deterrents. A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches, to the extent required by the Affordable Care Act (ACA).

Limitations

The benefits set forth in this section will be limited to:

Dosages.

1. With respect to the Pharmacy Option, any one prescription is limited to a 90 day supply..
2. With respect to the Mail Order Option, any one prescription is limited to a 90 day supply.
3. With respect to the Specialty Drug Option, any one prescription is limited to a 30 day supply.

Refills.

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician or as permitted by law.

Exclusions

In addition to the General Limitations and Exclusions section, the following are not covered under the Prescription Drug Benefit of the Plan:

Administration. Any charge for the administration of a covered Drug.

Allergy Sera. Charges for allergy sera.

Anorexiant. Anorexiant (weight loss Drugs), except as approved through the Prior Authorization Program

Anti-Aging Products. Drugs intended to affect the structure or function of the skin that cannot be purchased over-the-counter, including anti-wrinkle medications

Blood and Blood Plasma. Charges for blood and blood plasma.

Consumed Where Dispensed. Any Drug or medicine that is consumed or administered at the place where it is dispensed (except for insulin and Depo Provera).

Cosmetic pharmacological regiments.

De-pigmentation products used for skin conditions requiring a bleaching agent

Devices. Devices of any type, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device. Hearing aids are not covered under the prescription plan but may be covered as a medical item.

Durable Medical Equipment, except for:

- o Respiratory Therapy Supplies (e.g. Aerochamber, Spacers, Nebulizers)
- o Non-insulin syringes
- o Diabetic glucometers and diabetic insulin pumps.

Experimental Drugs. Experimental Drugs and medicines, even though a charge is made to the Participant. Products not approved for use in the United States, experimental therapy, or products purchased outside the United States, unless in an emergency situation.

Hair growth or removal treatments.

High Cost Generic Medications. Certain high cost generic medications are excluded as determined by the PBM.

Homeopathic Drugs (all dosage forms including injectable)

Immunizations. Immunization agents or biological sera except as mandated by the Affordable Care Act.

Immunologicals. Charges for immunologicals (vaccines).

Institutional Medication. A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises. Products used at or dispensed at a clinic, or doctor's office, including home care service, home infusion services

Investigational Use Drugs. A Drug or medicine labeled "Caution – limited by Federal law to Investigational use". Non-prescription drugs or medicines; prescription drugs that have not been classified as effective by the FDA; FDA approved therapeutic agents that are not administered according to generally accepted standards of practice in the medical community (Note: some non-FDA approved drugs may be covered as required by law. See section entitled "Legally Required Expenses"). This does not include drugs that: a) have been granted treatment investigational new drug (IND) or Group C/treatment IND status; b) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or c) for which available scientific evidence demonstrates, that the drug is effective or shows promise of being effective for the disease as determined by the pharmacy benefits manager.

No Charge. A charge for drugs which may be properly received without charge under local, State or Federal programs.

Non-Prescription Drug or Medicine. A drug or medicine that can legally be bought without a prescription, except for injectable insulin or OTC drugs that are prescribed by a Physician as required for Standard Preventive Care. Prescription medications with equivalent over the counter (OTC) formulations (e.g., proton pump inhibitors and seasonal allergy/antihistamine medications).

Medical foods and Dietary Supplements except as required for the treatment of PKU (phenylketonuria). Medical foods and dietary supplements include but are not limited to:

- a. Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas, protein shakes); or
- b. Prescription vitamins and supplements not identified as a coverage inclusion; or
- c. Medical food products that: are prescribed without a diagnosis requiring such foods; are used for convenience purposes; have no proven therapeutic benefit without an underlying disease, condition or disorder; are used as a substitute for acceptable standard dietary intervention; or are used exclusively or the enhancement of nutritional supplementation.

Over-the-Counter Drugs. Charges for over-the-counter drugs, except to the extent required by the Affordable Care Act:

1. Diagnostics. Diagnostic testing and imaging supplies, other than tests for COVID-19 (effective January 15, 2022), (e.g. Tubersol used for TB skin test, Radiopaque dye for outpatient testing)
2. Vitamins.

Prescription drugs for anyone other than the recipient of the prescription

Prescriptions exceeding a reasonable quantity as determined by your Physician in consultation with the Pharmacy Benefits Administrator.

Prescriptions including medications, devices and supplies whereby the Prescriber is acting on behalf of themselves or their family members are not covered. (Family is defined as those related by blood, marriage or residing in the same residence as the prescriber.) Prescription services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother, sister, aunt or uncle, whether the relationship is by blood or exists in law or as determined by Plan Administrator.

Sexual Dysfunction (Male and Female). A charge for sexual dysfunction medication, except when deemed medically necessary.

Steroids. Anabolic steroids.

Tobacco Cessation Care and treatment for tobacco cessation programs shall be covered to the extent required under Preventive Care, including smoking deterrent products. Tobacco cessation care and treatment is otherwise excluded unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.

Vitamins. Vitamins, except those mandated by the Affordable Care Act.

Treatment, services, and/or supplies excluded under the Plan may qualify for recommendation and approval for coverage as Alternative Treatment.

Participants will be held fully responsible for the use of any pharmacy identification card after termination of coverage.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rule”) set forth by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Such standards control the dissemination of “protected health information” (“PHI”) of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant’s PHI, and inform him/her about:

1. The Plan’s disclosures and uses of PHI.
2. The Participant’s privacy rights with respect to his or her PHI.
3. The Plan’s duties with respect to his or her PHI.
4. The Participant’s right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan’s privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-225-578-8200.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information (“PHI”) or Electronic Protected Health Information (“ePHI”) that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information (“PHI”)** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual’s PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.
The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse,

or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Louisiana State University
110 Thomas Boyd Hall
Baton Rouge, LA 70803
Phone: 1-225-578-8200

HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI)**, as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents**, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - i. Privacy Officer.
 - ii. Director of Employee Benefits.
 - iii. Employee Benefits Department employees.
 - iv. Information Technology Department.
 - b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. “Summary health information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

IMPORTANT NOTICES

Important Notice from LSU First About Your Prescription Drug Coverage and Medicare Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP) Civil Rights

Important Notice from LSU First About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with LSU First and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Board of Supervisors of Louisiana State University and Agricultural and Mechanical College has determined that the prescription drug coverage offered by the LSU First is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current LSU First coverage will be affected. See the LSU First Summary Plan Description for more information about your prescription drug coverage provisions/options.

If you do decide to join a Medicare drug plan and drop your current LSU First coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with LSU First and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through LSU First changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/1/2022
Name of Entity/Sender: LSU First
Contact—Position/Office: Katti Galatas, Asst. Plan Administrator
Address: 110 Thomas Boyd Hall, Baton Rouge
Phone Number: 225-578-8200

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

For information on other states or to see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

Civil Rights

LSU First complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LSU First does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

LSU First:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides 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, contact Human Resources.

If you believe that LSU First has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Human Resources, 110 Thomas Boyd Hall, Baton Rouge, LA 70803, Phone 225-578-8200, Fax 225-578-6571. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.