

**Plan Amendment and Summary of Material Modification (“SMM”)
for the LSU First Louisiana State University Health Plan
Effective January 1, 2022**

The Plan Document and Summary Plan Description is hereby amended as follows:

1. **The following language is DELETED from the section titled “General Information” in the Introduction And Purpose; General Plan Information section:**

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

And REPLACED with:

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

2. **The following language will be ADDED to the DEFINITIONS section:**

“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.

“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.

“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.

“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.

3. In the DEFINITIONS section, the definition of the term “Emergency Services” is DELETED and REPLACED with the following:

“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.

4. In the DEFINITIONS section, the definition of the term “Maximum Allowable Charge” is DELETED and REPLACED with the following:

“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 neither of these 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.

5. The following language is ADDED to the Claims Procedures; Payment of Claims section:

External Review Process

The 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 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).

6. The following provisions are ADDED to the What If Services Are Not Available from a Network Provider? provision within the Summary of Benefits section:

Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-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 Non-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.

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.

7. The following provision is ADDED In the Summary of Benefits section:

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.

8. In the Summary of Benefits section, the following provision is added:

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 Allowable 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.

9. In the Summary of Benefits section, the following provision is added before the HRA and Remaining Deductible for New Hires:

The following penalties apply to the specified services:

- \$150 = Advanced Imaging-CT/MRI/SPECT if performed in a hospital setting.
- \$300 = Outpatient Surgery if performed in a hospital setting. Does not apply to colonoscopies and wound care.

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

10. The underlined wording is CHANGED in the Medical Expense Out-of-Pocket Maximum in the Summary of Benefits section:

LSU First Option 1	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
Out-of-Pocket Maximum			
<i>Employee Only</i>	<i>Not Applicable¹</i>	\$4,500	Unlimited ³
<i>Employee + Spouse</i>	<i>Not Applicable¹</i>	\$6,750	Unlimited ³
<i>Employee + Child(ren)</i>	<i>Not Applicable¹</i>	\$6,750	Unlimited ³
<i>Family</i>	<i>Not Applicable¹</i>	<u>\$9,000⁴</u>	Unlimited ³

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 \$8,700.

11. The following language will be ADDED to the item titled “2019 Novel Coronavirus (COVID-19)” in the Medical Benefits section:

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.

12. The following language will be ADDED to the Medical Benefits section:

Sexual Dysfunction. Limited to sexual counseling, or therapy, implants and hormonal therapy for dysfunction due to organic disease.

13. The following language is DELETED from the section titled “Medical Exclusions” in the Medical Benefits section:

Infertility services when the infertility is caused by or related to voluntary sterilization.

Sexual Dysfunction. For any treatment of a sexual dysfunction, including but not limited to sexual counseling or therapy, implants and hormonal therapy, except of dysfunction due to organic disease or gender dysphoria, 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.

And REPLACED with:

Infertility services when the infertility is caused by or related to voluntary sterilization, or for dependents other than a spouse.

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.

14. In the Utilization Management section, the list of Services that Require Pre-Certification is DELETED and REPLACED with the following:

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. Substance Abuse programs require mandatory Care Coordination enrollment
- Residential Treatment (RTC). Substance Abuse programs require mandatory Care Coordination enrollment

Transplants (excluding cornea)

- Evaluation
- Listing

Medications

- Injectables billed under the medial 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 Scan/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

15. The following language is DELETED from the section titled “Exclusions” in the Prescription Drug Benefits section:

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 (e.g. Tubersol used for TB skin test, Radiopaque dye for outpatient testing)
2. Vitamins.

And REPLACED with:

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.

All other sections of the Plan remain unchanged.

BY THIS AGREEMENT,

**The Plan Document and Summary Plan Description for the
LSU First Louisiana State University Health Plan
is hereby Amended January 1, 2022.**

Authorized Signature _____

Print Name _____

Title _____

Date _____

IMPORTANT NOTICE:

By signing this page the employer agrees to all sections of this amendment as a basis for plan administration. Except as specifically stated above, nothing in this amendment shall alter or amend the summary plan description.

Lack of a signature page can lead to incomplete coding of the claim payment system, and inconsistencies in claims and appeal processing.

Furthermore, Stop-loss policies do not provide coverage for plan terms or conditions unknown to them. Notice to the stop loss carriers is required.

Please sign and return to WebTPA as soon as possible.

Remember to keep a copy for your records, and also submit a copy of the signed amendment and current summary plan description to your stop loss carrier to prevent any possible lapse or gap in stop loss coverage.

Any modifications made to this amendment will cause it to become null and void and require that a new signature page be signed.