Louisiana State University System Health Plan

Summary Plan Description
Effective January 1, 2014 – December 31, 2014

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WebTPA
Claim Administrator

EXPRESS SCRIPTS
Pharmacy Benefit Manager
# Table of Contents

SUMMARY OF BENEFITS AND COVERAGE ................................................................. 3
LSU FIRST OVERVIEW ............................................................................................ 3
LSU FIRST HIGHLIGHTS AND PLAN CHANGES FOR 2014 ........................................ 5
HOW LSU FIRST WORKS ..................................................................................... 7
NETWORKS ............................................................................................................. 17
ELIGIBILITY ........................................................................................................... 21
EFFECTIVE DATE .................................................................................................. 28
ENROLLMENT ......................................................................................................... 29
LEAVE OF ABSENCE ............................................................................................ 29
CONTINUATION RIGHTS UNDER FEDERAL LAW ("COBRA") .................................. 31
HRA COMPARED TO FLEXIBLE BENEFIT PLAN ...................................................... 35
COVERED SERVICES ............................................................................................. 36
MEDICAL MANAGEMENT ..................................................................................... 59
BENEFIT LIMITS AND EXCLUSIONS UNDER THE PLAN ....................................... 61
FILING CLAIMS FOR BENEFITS OTHER THAN CRITICAL ILLNESS DIRECT CASH BENEFITS ................................................................. 67
COORDINATION OF BENEFITS (COB) .................................................................. 69
MEDICAL NECESSITY DETERMINATIONS AND APPEALS ................................. 74
APPEALS/COMPLAINTS FOR SERVICES OTHER THAN MEDICAL NECESSITY .......... 79
OTHER PLAN INFORMATION ............................................................................... 81
DEFINITIONS ........................................................................................................ 84
IMPORTANT NOTICES

WOMANS HEALTH AND CANCER RIGHTS ACT .................................................... 103
PRESCRIPTION DRUG COVERAGE AND MEDICARE NOTICE ............................... 104
HIPAA PRIVACY PRACTICES NOTICE .................................................................. 107
PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) .............................................................. 114
SUMMARY OF BENEFITS AND COVERAGE

LSU has made available online an easy-to-understand Summary of Benefits and Coverage ("SBC") for this Plan in accordance with government regulations. It is available at www.lsufirst.org or by contacting your employer’s Human Resources department. The SBC includes:

- A short, plain language Summary of Benefits and Coverage
- A uniform glossary of terms commonly used in health insurance coverage, such as "Deductible" and "Copayment"

LSU FIRST OVERVIEW

LSU First (or "the Plan") provides you comprehensive health and preventive care coverage that gives you a unique, consumer-directed healthcare approach to pay routine health expenses and provides coverage for major healthcare expenses.

This is not an insured benefit plan. The benefits described in this Summary Plan Description ("SPD") are self-insured by the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College ("LSU") which is responsible for their payment. WebTPA Employer Services, LLC ("WebTPA") provides claim administration services to the Plan, but WebTPA does not insure the benefits described.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider’s license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Participating Provider.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

The Plan:

- Let’s you choose your Provider (no referrals required)
- Includes a Health Reimbursement Account ("HRA") funded entirely by your Employer
• Covers qualifying Preventive Care Services at 100% when utilizing Network Providers/Facilities (including First Choice Providers) Provides four Coverage Tiers (so you can select a coverage level appropriate for you and your family)
  o Employee Only
  o Employee plus Spouse
  o Employee plus Child(ren)
  o Family
LSU FIRST HIGHLIGHTS AND PLAN CHANGES FOR 2014

The Plan Year is based on a 12-month calendar year beginning January 1 and ending on December 31.

WebTPA is the Claim Administrator, including the provision of a national Provider network, medical management services (including pre-determination of medical necessity), case management, and disease management, Employee Assistance Program (EAP), and Wellness programs. Express Scripts Inc. (ESI) provides all prescription drug services, including retail, mail order, and specialty drugs. Verity HealthNet (VHN) provides First Choice and local network access. Member Advocates are available to all Plan Members for questions and problem resolution.

Federal Health Care Reform Legislation (Affordable Care Act of 2010; Health Care Education and Reconciliation Act of 2010)

Questions regarding the Affordable Care Act can be directed to the Plan Administrator at:

A.G. Monaco, Plan Administrator
LSU System Health Plan
The Louisiana State University System
304 Thomas Boyd Hall
Baton Rouge, Louisiana 70803
225.578.4904
amonaco@lsu.edu

You may also contact the U.S. Department of Health and Human Services at 1-877-696-6775 or www.hhs.gov. Please see "Important Notices" section beginning on page 109 for more on your individual rights to benefits and information.

Affordable Care Act Form W-2 Reporting

Employers must report the aggregate cost of employer-sponsored coverage (employee plus employer portion) for each employee on an employee's Form W-2. Coverage to be reported includes: medical, prescription, dental and vision (unless provided as a "stand-alone" plan(s), executive physicals, on-site clinics, Medicare supplemental policies, and employee assistance programs (EAPs).

The cost is determined using the COBRA rules for determining "applicable premium". The value does not include HSA or FSA contributions, or specific disease or hospital/fixed indemnity plans.

Affordable Care Act Notice of Modification

The Plan must provide notice of any material modification to the Plan terms or coverage no later than 60 days prior to the effective date of the change.

NOTICE OF CHANGES IN LSU FIRST FOR 2014

LSU First is a not-for-profit Health Plan administered by LSU for the benefit of LSU Employees, Employees of Participating and/or Successor Employers and respective Dependents and Retirees. The following aspects of the Plan remain unchanged for 2014:

- You will not incur Out-of-Pocket expense for Covered Services from First Choice providers and/or for Generic Prescription Drugs
• Your Health Reimbursement Account (HRA) will remain the same (this is the amount of your Deductible that LSU pays on your behalf)
• Your Remaining Deductible (the part you pay) will remain the same
• Your Prescription Drug Co-Payments will remain the same
• The Plan will continue to encourage the use of mail order for many maintenance medications by asking Members to make an active selection to continue to fill these medications at their retail pharmacy.
• The Plan will require prior authorization for certain medications

In order to preserve the financial integrity of the Plan, the following changes are effective January 1, 2014:

• The Out-of-Pocket Maximum has increased.
• The Plan will enhance programs to make sure that prescription drugs are being used for legitimate medical purposes and in appropriate dosages.
• Due to changes in the Plan’s stop loss reinsurance coverage, Group Term Life Insurance of $25,000 and Accidental Death and Dismemberment coverage of $25,000 is discontinued.
HOW LSU FIRST WORKS

LSU First offers two Plan options. **Option 1** has a lower Deductible and a higher premium rate, while **Option 2** has a higher Deductible and a lower premium rate.

LSU First consists of three separate components:
1. Deductible (HRA and Remaining Deductible)
2. Co-Insurance for Covered Medical Services (up to the Out-of-Pocket Maximum)
3. Co-Payments for Brand Name and Specialty Prescription Drugs

**Note:**

*The HRA and the Remaining Deductible for Plan Year 2014 remain unchanged from 2013*

1. **The Deductible**
   The Deductible includes your Health Reimbursement Account (HRA) and your Remaining Deductible. The amount of your Deductible is based on your Coverage Tier and the effective date of your coverage.

   **Overview of the HRA**

   The LSU System funds 100% of your HRA at the beginning of each Plan Year (January 1). The HRA pays for 100% of Covered Medical Expenses and Prescription Drug costs from any Healthcare Provider until the HRA is exhausted.

   **Annual HRA Contribution**

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Employee plus Spouse</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Employee plus Child(ren)</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

   **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 not be used to pay for First Choice Providers, but will be used for other Covered Medical and Pharmacy Expenses. Your combined total HRA Rollover and new allocations of HRA may not exceed the following amounts in a Plan Year:

   **Annual Total HRA Maximum**

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$4,000</td>
</tr>
<tr>
<td>Employee plus Spouse</td>
<td>$6,000</td>
</tr>
<tr>
<td>Employee plus Child(ren)</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$8,000</td>
</tr>
</tbody>
</table>
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 and Generic Drugs will be paid at 100% by LSU First after your current Plan Year 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 remainder of your Deductible. **Covered Medical Expenses at First Choice Providers and Generic prescription drugs 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 and for Brand Name and Specialty Prescription Drugs 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

<table>
<thead>
<tr>
<th>Plan Option and Coverage Tier</th>
<th>Deductible Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LSU First Option 1</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employee Only</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$1,000</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$500</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$1,500</strong></td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$1,500</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$750</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$2,250</strong></td>
</tr>
<tr>
<td><strong>Employee + Child(ren)</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$1,500</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$750</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$2,250</strong></td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$2,000</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$1,000</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$3,000</strong></td>
</tr>
<tr>
<td><strong>LSU First Option 2</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employee Only</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$1,000</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$1,500</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$2,500</strong></td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$1,500</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$2,250</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$3,750</strong></td>
</tr>
<tr>
<td><strong>Employee + Child(ren)</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$1,500</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$2,250</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$3,750</strong></td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
<td>$2,000</td>
</tr>
<tr>
<td>Remaining Deductible</td>
<td>$3,000</td>
</tr>
<tr>
<td>Total Deductible</td>
<td><strong>$5,000</strong></td>
</tr>
</tbody>
</table>
The Chart below illustrates how the Deductible works.

Please note: this Chart utilizes LSU First Option 1 Employee Only coverage as an example. The Deductible works the same way in Option 1, Option 2 and with all four Coverage Tiers. However, the amount of the Deductible will vary according to the Plan Option and Coverage Tier selected.

**Deductible Example: Employee-Only Coverage Option 1**

- **Total Annual Deductible**
  - (Employee-Only Coverage)
  - $1,500

- **HRA**
  - Health Reimbursement Account
  - Funded Annually by Employer
  - $1,000

- **Remaining Deductible**
  - What You Owe after Your HRA Is Exhausted
  - $500

Remaining Deductible is not applicable when you access First Choice Providers or select Generic Drugs.
You pay $0
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).

<table>
<thead>
<tr>
<th>EFFECTIVE DATE</th>
<th>Employee Only</th>
<th>Employee + Spouse</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee Only</td>
<td>Employee + Spouse</td>
<td>Family</td>
</tr>
<tr>
<td>January 1st</td>
<td>$1,000.00</td>
<td>$1,500.00</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>February 1st</td>
<td>$917.00</td>
<td>$1,375.00</td>
<td>$1,833.00</td>
</tr>
<tr>
<td>March 1st</td>
<td>$833.00</td>
<td>$1,250.00</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>April 1st</td>
<td>$750.00</td>
<td>$1,125.00</td>
<td>$750.00</td>
</tr>
<tr>
<td>May 1st</td>
<td>$667.00</td>
<td>$1,000.00</td>
<td>$750.00</td>
</tr>
<tr>
<td>June 1st</td>
<td>$583.00</td>
<td>$875.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>July 1st</td>
<td>$500.00</td>
<td>$750.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>August 1st</td>
<td>$417.00</td>
<td>$625.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>September 1st</td>
<td>$333.00</td>
<td>$500.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>October 1st</td>
<td>$250.00</td>
<td>$375.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>November 1st</td>
<td>$167.00</td>
<td>$250.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>December 1st</td>
<td>$83.00</td>
<td>$125.00</td>
<td>$500.00</td>
</tr>
</tbody>
</table>

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” on page 29), 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.
In each of the following examples, additions or reductions to the Deductible assume that no claims were paid for the period of January 1 through December 31.

Example of an Increase in Coverage Tier:

On January 1<sup>st</sup> you are enrolled in Option 1 and your Coverage Tier is Employee Only.

- Your HRA is $1,000, and
- Your Remaining Deductible is $500

On July 1<sup>st</sup> you get married and your new Coverage Tier is Employee + Spouse.

- The HRA difference between these two coverage tiers is $500. Based on six months of remaining coverage, the $500 amount is prorated for six months and the additional funds are $250.
- The $250 is added to your $1,000 HRA for a total of **$1,250**.
- The Remaining Deductible difference between these two coverage tiers is $250. Based on six months of remaining coverage, the $250 amount is prorated for six months and the increase in your Remaining Deductible is $125.
- The $125 is added to your original Remaining Deductible of $500, for a new Remaining Deductible of **$625** for the remainder of the Plan Year.
- Your new Deductible is your new HRA ($1,250) plus your new Remaining Deductible ($625), for a total new Deductible of **$1,875** for the remainder of the Plan Year.
- Any amounts already paid toward your Deductible prior to the change in Coverage Tier will be applied to the Deductible, as appropriate.

Example of a Decrease in Coverage Tier:

On January 1<sup>st</sup> you are enrolled in Option 1 and your Coverage Tier is Employee and Spouse.

- Your HRA is $1,500, and
- Your Remaining Deductible is $750

On July 1<sup>st</sup> you get divorced and your new Coverage Tier is Employee Only.

- The HRA difference between these two Levels of Coverage is $500. Based on six months of remaining coverage, the $500 is prorated for six months and the reduction in HRA is $250.
- The $250 is subtracted from your original $1,500 HRA for a new HRA total of **$1,250**.
- The Remaining Deductible difference between these two Levels of Coverage is $250. Based on six months of remaining coverage, the $250 amount is prorated for six months and the reduction in your Remaining Deductible is $125.
- The $125 is subtracted from your original Remaining Deductible of $750, for a new Remaining Deductible of **$625** for the remainder of the Plan Year.
- Your new Deductible is your new HRA ($1,250) plus your new Remaining Deductible ($625), for a total new Deductible of **$1,875** for the remainder of the Plan Year.
- If you have less than $250 remaining in your HRA at the time of the proration, the amount subtracted from your HRA will not exceed the amount remaining.
- If at the time of the proration, you have already incurred expenses in excess of your new, reduced Remaining Deductible, you will not receive any credit for the excess amount that you have incurred.
You can keep track of your Deductible online at www.lsufirst.org by selecting "My Accounts" and then "webtpa.com" or by calling the toll-free customer service number 1-855-346-LSU1.
2. **Co-Insurance for Covered Medical Expenses**

After you have satisfied your Deductible, you enter the Co-Insurance for Medical Expenses component of the Plan. You pay a percentage of Covered Medical Expenses until you have reached the Out-of-Pocket Maximum for your Coverage Tier. The Co-Insurance component of the Plan applies only to Covered Expenses of Medical Providers. See below for an explanation of how Prescription Drug Expenses are covered.

**Important Note**

Brand Name and Specialty Prescription Drugs (collectively “Brand and Specialty Drugs”) are not subject to Co-Insurance. Brand and Specialty Drugs are subject to a Co-Payment for which there is no applicable Out-of-Pocket Maximum. Please see “Brand Name and Specialty Prescription Drug Co-Payments” on page 16.

**Remember: After your HRA is exhausted, LSU First pays 100% of Covered Expenses to First Choice Providers and for Generic Drugs. Therefore, you pay nothing out-of-pocket for First Choice Providers and Generic Drugs.**

**Medical Services In-Network Co-Insurance**

For In-Network Providers, the maximum Plan liability is the Contracted Reimbursement Rate (“Contract Rate”). The Plan pays 90% and you pay 10% 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 Co-Insurance**

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

- 30% of the Maximum Reimbursable Charge (MRC) for Covered Expenses; and
- any amount over the MRC

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

**Maximum Co-Insurance**

To protect you, LSU First has established the maximum amount you will pay in the Co-Insurance component. Your percentage of Co-Insurance for Covered Medical Expenses accumulates toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum varies based on your Coverage Tier and whether or not services are rendered by an In-Network or Out-of-Network Provider. Your Covered Medical Expenses, as well as the Covered Medical Expenses of your Dependents, contribute towards the Out-of-Pocket Maximum.
### Medical Expense Co-Insurance and Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th></th>
<th>First Choice Provider</th>
<th>In-Network Provider (Aetna Signature Administrators PPO and Verity HealthNet Providers)</th>
<th>Out-of-Network Provider (A non-contracted Provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Insurance You Pay</td>
<td>$0</td>
<td>10% of Covered Expenses</td>
<td>30% of MRC(^2) for Covered Expenses plus any amount above the MRC(^3)</td>
</tr>
</tbody>
</table>

**LSU First Option 1**

**Out-of-Pocket Maximum**

- **Employee Only**: Not Applicable\(^1\)
  - In-Network: $2,000
  - Out-of-Network: $5,000\(^3\)

- **Employee + Spouse**: Not Applicable\(^1\)
  - In-Network: $3,000
  - Out-of-Network: $7,000\(^3\)

- **Employee + Child(ren)**: Not Applicable\(^1\)
  - In-Network: $3,000
  - Out-of-Network: $7,000\(^3\)

- **Family**: Not Applicable\(^1\)
  - In-Network: $4,000
  - Out-of-Network: $9,000\(^3\)

**LSU First Option 2**

**Out-of-Pocket Maximum**

- **Employee Only**: Not Applicable\(^1\)
  - In-Network: $2,000
  - Out-of-Network: $6,000\(^3\)

- **Employee + Spouse**: Not Applicable\(^1\)
  - In-Network: $3,000
  - Out-of-Network: $8,000\(^3\)

- **Employee + Child(ren)**: Not Applicable\(^1\)
  - In-Network: $3,000
  - Out-of-Network: $8,000\(^3\)

- **Family**: Not Applicable\(^1\)
  - In-Network: $4,000
  - Out-of-Network: $10,000\(^3\)

\(^1\)After your HRA is exhausted, LSU First pays 100% for First Choice Providers and Generic Drugs. Therefore, you pay nothing out-of-pocket for First Choice Providers and Generic Drugs.

\(^2\)Maximum Reimbursable Charge (also known as Usual and Customary or Reasonable and Customary Charge)

\(^3\)The Out-of-Pocket Maximums listed above are for Covered Medical Expenses only. For Out-of-Network Providers, LSU First will pay 100% of the MRC once the Out-of-Pocket Maximum is reached. Charges exceeding the MRC will be the Member’s responsibility.
3. BRAND NAME AND SPECIALTY PRESCRIPTION DRUG CO-PAYMENTS

Once your Deductible has been satisfied, you will be responsible for a Co-Payment of $40 for each 30 days’ supply of Brand Name prescription drugs and $120 for each 30 days’ supply of Specialty prescription drugs filled. Co-Payments are not subject to an annual Out-of-Pocket Maximum and continue for the duration of the Plan Year. Co-Payments are not applicable to Generic Drugs, which are paid at 100% after the HRA is exhausted.

If your Deductible is satisfied by only a portion of the total cost of a Prescription drug transaction, you will be responsible for the amount required to satisfy your Deductible PLUS either the remainder of the cost of the drug or the applicable Co-Payments, whichever is less. For example, if you purchase a Brand Name prescription drug that costs $200 for a 30-day supply at the time that you have $50 remaining on your Deductible, you will pay $50 plus a $40 co-payment for a total of $90. If, on the other hand, you purchase the same Prescription drug when you have $175 remaining on your Deductible, you will pay $175 plus the remaining $25 cost of the drug for a total of $200.

If an equivalent Generic Drug is available and you elect the Brand-Name Drug, you will be responsible for payment of the difference in cost between the Generic and the Brand Name Prescription Drug.

Examples of How the Prescription Drug Benefit Works (the examples assume no HRA Rollover funds are available)

Scenario One:
You have HRA funds available. When you go to an In-Network pharmacy, the prescription will be paid from your HRA and the amount will be applied to your Deductible.

Scenario Two:
You do not have HRA funds available, and you have not satisfied your Remaining Deductible. You receive a prescription for a Generic Drug. When you go to an In-Network pharmacy, you receive the Generic prescription at no cost to you.

Scenario Three:
You do not have HRA funds available, and you have not satisfied your Remaining Deductible. You receive a prescription for a Brand Name Drug that has no Generic equivalent. When you go to an In-Network pharmacy, you will be responsible for the cost of the Brand Name Drug up to the amount of your Remaining Deductible.

If the cost of the Brand Name Drug exceeds your Remaining Deductible balance, you will be responsible for the amount required to satisfy your Remaining Deductible PLUS either the applicable Co-Payment(s) or the remainder of the cost of the drug, whichever is less.

Scenario Four:
You fill your prescription at an Out-of-Network pharmacy. You will have to pay the entire cost at the time you purchase your prescription. You may then file a claim for reimbursement with the Pharmacy Benefits Manager. Subject to satisfying your Remaining Deductible and the applicable Co-Payment(s), you will be reimbursed by the Plan based on the In-Network contracted rate for a Covered Prescription Drug Expense. You are responsible for any difference between the Out-of-Network pharmacy’s price and the Plan’s level of reimbursement.

HRA Rollover, if any, is not expended to pay First Choice Providers or for Generic Drugs.
NETWORKS

**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 Co-Insurance component are not applicable when using a First Choice Provider. Your HRA Rollover, if any, will not be used to pay First Choice Providers (see section entitled “How Your Choice of Provider Affects You” on page 18).

**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 Co-Insurance 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.lsufirst.org 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. Please also be aware that some First Choice facilities may use ancillary providers such as emergency room physicians, pathologists, 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.

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 90% of the Maximum Reimbursable Charge (MRC), as determined by the Plan. You may still be responsible for any amounts in excess of the MRC.

To ensure that benefits for services from an Out-of-Network Provider qualify to be reimbursed at 90% of the MRC, prior approval must be obtained by calling 1-855-346-LSU1 and selecting the Medical Management option.

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. The chart below compares the financial impact of using a First Choice Provider, an In-Network Provider, and an Out-Of-Network Provider.

Assume the following (see chart below):

- You need an outpatient surgical procedure;
- You have Family coverage under Option 1; and
- You have $500 remaining in your HRA and have not met your Remaining Deductible ($1,000).
<table>
<thead>
<tr>
<th>Category</th>
<th>First Choice Provider</th>
<th>In-Network Provider (Aetna ASA or Verity HealthNet Providers)</th>
<th>Out-of-Network Provider (Non-Contracted Provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed Charge for Procedure</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Plan Allowed Amount (Covered Expense)</td>
<td>$5,500</td>
<td>$7,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Amount Paid from HRA</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Remaining Deductible (Your portion of the Deductible)</td>
<td>$0</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Co-Insurance Paid by You</td>
<td>0% ($0)</td>
<td>10% of Plan Allowed Amount ($550)</td>
<td>30% of Maximum Reimbursable Charge ($1,350)</td>
</tr>
<tr>
<td>Additional Amount Provider May Bill You</td>
<td>$0</td>
<td>$0</td>
<td>$4,000 ($10,000 Billed Charge - $6,000 Maximum Reimbursable Charge)</td>
</tr>
<tr>
<td>Your Total Expense for this Outpatient Surgical Procedure</td>
<td>$0</td>
<td>$1,550 ($1,000 Remaining Deductible + $550 Co-Insurance)</td>
<td>$6,350 ($1,000 Remaining Deductible + $1,350 Co-Insurance + $4,000 above the Maximum Reimbursable Charge)</td>
</tr>
</tbody>
</table>

**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.lsufirst.org for assistance in locating the nearest In-Network Provider. If you need emergency care while traveling, however, go ahead and get the care you need, and the Plan will pay Covered Expenses at 90% of Maximum Reimbursable Charge (MRC) (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 MRC 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

**Preventive Care**
The Plan covers qualifying Preventive Care Services at 100% at a First Choice or In-Network Provider/Facility. You do not need to spend your HRA dollars for qualifying Preventive Care Services, and such services are covered with no Remaining Deductible (your portion of the Deductible) to satisfy. For a complete list of qualifying Preventive Care Services, see the section entitled, “Preventive Care/Wellness” on page 49. You may receive additional non-qualifying Preventive Care Services; however, any such services
will be considered as any other claim, subject to applicable Plan provisions. If you choose to use an Out-of-Network provider or facility for qualifying Preventive Care Services, the Plan will pay 100% of the Maximum Reimbursable Charge (MRC) for these services; you will be responsible for any amounts in excess of the MRC.

**Accessing LSU First Plan Information and Your Personal Account Information Online**

First, go to [www.lsufirst.org](http://www.lsufirst.org). 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.lsufirst.org](http://www.lsufirst.org), you can click on “My Accounts” to access both webtpa.com and [www.express-scripts.com](http://www.express-scripts.com).

At 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 webtpa.com:

- Go to [www.lsufirst.org](http://www.lsufirst.org) and click on “My Accounts”
- Click on the webtpa.com link.
- From 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 access:

- 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.express-scripts.com](http://www.express-scripts.com), you can:

- Review your claims, check prescription drug prices, order home delivery refills, check the cost of your prescription medications, identify opportunities to save money, and find pharmacy-specific pricing and options for home delivery.
- Compare drug treatment options for more than 200 common medications. You can better understand side effects, drug interactions and alternative treatments.
- Order and track home delivery prescriptions and review your prescription drug history.

To register at [www.express-scripts.com](http://www.express-scripts.com):

- Go to [www.lsufirst.org](http://www.lsufirst.org) and click on “My Accounts”
- Click on [www.express-scripts.com](http://www.express-scripts.com)
- Select “Create Online Account” in the middle of the page.
- Enter your personal identifying information and Member ID number, which you can find on your LSU First Member ID card.
- Create a user name and password
ELIGIBILITY

Employee Eligibility Requirements

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

1. a full-time Employee of the Louisiana State University System ("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). No person appointed on a restricted appointment, or a temporary appointment, will be considered an eligible Employee; or
2. a 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; or
3. a former full-time Employee of the Louisiana State University System; 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:
   a. was participating in the Plan at the time such former employment ceased; and
   b. transfers and/or assumes full-time employment with an Office of Group Benefits (OGB) participating employer other than the Louisiana State University System, or the Louisiana Legislative Branch; and
   c. elects to continue to participate in the Plan in accordance with OGB rules governing inter-agency 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) Board of Supervisors of Louisiana State University and Agricultural and Mechanical College; and
   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; and
   e. whose successor OGB participating employer ("Successor Employer") remits to the Louisiana State University System 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 State Senate, the Office of the Legislative Auditor, the Legislative Fiscal Office and the Legislative Budgetary Control Council, in favor of the Louisiana State University System.

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

Re-Enrollment

1. An Employee, whose employment terminated while covered and is re-employed within 12 months of the termination date, will be considered as a Re-Enrolled Previous Employment applicant, eligible to re-enroll in the Plan, subject to applicable Plan provisions. A Re-Enrolled Previous Employment applicant will only be eligible for the classification of coverage (Employee, Employee and Child(ren), Employee and Spouse, Family) in force on the effective termination date.
2. If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within 30 days of re-employment.

Members of Boards and Commissions

Except as otherwise provided by law, members of boards or commissions are not eligible for participation in the Plan unless defined by the Participant Employer as full time Employees.

Legislative Assistants

Legislative Assistants are eligible to participate in the Plan if they are declared full-time Employees by the Participant Employer and have at least one year of experience or receive at least 80% of their total compensation as Legislative Assistants.

HIPAA Employee Special Enrollment
In accordance with HIPAA, certain eligible persons for whom the option to enroll for coverage was previously declined, and who would be considered overdue applicants, may enroll by written application to the Participant Employer under the following circumstances, terms, and conditions for special enrollments:

1. Loss of Other Coverage -- Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined because the Employees or Dependents had other coverage which terminated due to:
   a. Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan Participant; or
   b. Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer’s contributions were ceased for cause or for failure of the individual Participant to make contributions; or
   c. The Employee or Dependent having had COBRA continuation coverage under a Group Health Plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA; or
   d. Effective April 1, 2009: Loss of eligibility due to termination of Medicaid or State Children’s Health Insurance (SCHIP) coverage; or
   e. Effective April 1, 2009: Eligibility for premium assistance subsidy under Medicaid or SCHIP.

2. After Acquired Dependents -- Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined when the Employee acquires a new Dependent by marriage, birth, adoption, or placement for adoption.
   a. A special enrollment application must be made within 30 days of the termination date of the prior coverage or the date the new Dependent is acquired, as applicable, or within sixty (60) days as identified in (d) and (e) above. The effective date of coverage shall be:
      i. For loss of other coverage or marriage, the first day of the month following the date the Plan receives all required forms for enrollment;
      ii. For birth of a Dependent, the date of birth;
      iii. For adoption, the date of adoption or placement for adoption.
   b. Special enrollment applicants may be required to complete a “Statement of Physical Condition” form.

**Dependent Eligibility Requirements**

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;
2. A Child from date of birth up to 26 years of age;
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).
5. 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” on page 24 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.

**Over-Age Dependents**

If a Dependent Child is incapable (and became incapable prior to attainment of age 26) of self-sustaining employment, the coverage for the Dependent Child may be continued for the duration of incapacity.
1. Prior to the Child reaching age 26, an application for continued coverage with current medical information from the Child’s attending Physician must be submitted to the Office of Group Benefits to establish eligibility for continued coverage as set forth above. Upon receipt of the application for continued coverage, the Office of Group Benefits may require additional medical documentation regarding the Child’s mental retardation or physical incapacity as often as he may deem necessary thereafter.

**Dependent Verification Requirements for LSU First**

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. For newborn Children, such proof shall be submitted to your Human Resources Department no later than six months from the Child’s date of birth

**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 HRM 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; 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 for whom you have been granted guardianship or legal custody, including provisional 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

6. **Grandchild for whom you do not have legal custody or guardianship but who is dependent on you for support and whose parent is a covered Dependent:**
   Certified birth certificate or adoption decree showing parent of Grandchild is a Dependent Child and certified copy of birth certificate showing Dependent Child is a parent of Grandchild

7. **Child 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:**
a. Certified copy of birth certificate listing Plan Member as parent; or
b. Certified copy of legal acknowledgment of paternity signed by plan member; or
c. Certified copy of adoption decree naming Plan Member as adoptive parent
d. Must also apply for continued coverage prior to age 26 and provide supporting medical documentation
e. Must provide additional medical documentation of Child’s condition periodically upon request by the Plan

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

It may take several months to obtain necessary documents to verify the status of your Dependents. For information about recovering copies of lost vital records, contact your local Human Resources Management Department.

**Qualified Medical Child Support Order**

**Eligibility for Coverage Under a QMCSO**
If a Qualified Medical Child Support Order (QMCSO) is issued for your Child, that Child will be eligible for coverage as required by the order and will not be considered a Late Entrant for Dependent Insurance. You must notify your Employer and elect coverage for that Child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

**Qualified Medical Child Support Order Defined**
A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for Child support or provides for health benefit coverage for such Child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a Child’s right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the Child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child’s mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

**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.
Retiree Eligibility Requirements

Eligibility
1. Retirees of Participant Employers are eligible for Retiree coverage under this Plan.
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.
3. An Employee retired from a Participant Employer may not be covered as an Employee.
4. Retirees are not eligible for coverage as late applicants.

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 + Choice/Medicare Advantage Option for Retirees
Retirees who are eligible to participate in a Medicare+Choice/Medicare Advantage plan who cancel coverage with the Plan upon enrollment in a Medicare+Choice/Medicare Advantage plan may re-enroll in the Plan upon withdrawal from or termination of coverage in the Medicare+Choice/Medicare Advantage plan, at the earlier of the following:
1. During the month of November, for coverage effective January 1; or
2. During the next annual enrollment, for coverage effective at the beginning of the next Plan Year.

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.

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.
   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, or a plan sponsored by the Office of Group Benefits;
   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 new Dependents to continued coverage other than a Child of the deceased Employee born after the Employee’s death.

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;
   b. The Human Resource Department will notify the surviving Dependents of their right to continue coverage;
   c. Application for continued coverage must be made in writing to their Human Resource Department within 360 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;
   d. Coverage for the surviving spouse under this section will continue until the earliest of the following:
      i. Failure to pay the applicable premium timely;
      ii. Eligibility of the surviving spouse under a Group Health Plan other than Medicare.
   e. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:
      i. Failure to pay the applicable premium 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.

**Change of Classification**

The Plan Member must notify their Human Resource Department when a Dependent is added to or deleted from the Plan Member'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.

**Notification of Change**

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 is later determined, it will be corrected on the first day of the following month.
Termination of Coverage

Employee and Retired Employee Coverage
Subject to continuation of coverage and COBRA rules, coverage will terminate under this Plan on the earliest of the following dates:

- The date you cease to be an Eligible Employee or cease to qualify for the Plan
- The last day for which you have made any required contribution for Plan coverage
- The date the Plan is terminated
- The last day of the calendar month in which your status as an Employee ends, except as described in the Leave of Absence section as set forth in this document

Dependent Coverage Only
Subject to continuation of coverage and COBRA rules, coverage will terminate under this Plan on the earliest of the following dates:

- The last day of the month the Employee ceases to be covered
- The last day of the month in which the Dependent, as defined in this Plan, ceases to be an eligible Dependent of the covered Employee
- For Grandchildren for whom the Employee does not have legal custody or has not adopted, the date the Child's parent ceases to be a covered Dependent under this Plan or the Grandchild no longer meets the definition of Children
- Upon discontinuance of all Dependent coverage under this Plan
EFFECTIVE DATE

Employee Effective Dates of Coverage (New Employee and Transferring Employee)
Coverage for each Employee who completes the applicable Enrollment Form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

1. 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.

2. Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will be considered a late applicant.

3. 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. If completed after 30 days following the date of transfer, the Employee will be considered a late applicant.

Employee/Dependent Date of Coverage for Late Applicants
A “Late Applicant” is an Eligible Employee/Dependent who applies for Coverage after the expiration of 30 days from the date the Employee first became Eligible for Coverage. With respect to Dependents, a “Late Applicant” is an Eligible Dependent for whom the application for Coverage was not completed within 30 days from either the Employee’s first Eligibility Date or from the Dependent’s first Eligibility Date.

The terms of the following paragraphs apply to Late Applicants. The effective date of coverage will be:
1. The first day of the month following the date the Plan receives all required forms as of the 14th of the month; for example, if Late Applicant forms are submitted by July 14th, coverage will be Effective August 1st.
2. The first day of the second month following the date the Plan receives all required forms on or after the 15th of the month; for example, if Late Applicant forms are submitted after July 14th coverage will be Effective September 1st.

Dependent Effective Date of Coverage
1. Dependents of Employees -- Coverage will be effective on the date the Employee becomes eligible for Dependent Coverage.
2. 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.

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).
ENROLLMENT

You will receive a packet of information including a benefits election form when you become eligible. You will use the benefits election form to enroll in (or decline) the Plan and to authorize your Employer to deduct your contributions from your pay. In order not to be considered a Late Applicant, you must sign and return this form to your Human Resources Management Department within 30 days of your date of hire. To the extent you want to enroll your Dependents, you must do so within 30 days of your date of hire in order for them not to be considered Late Applicants.

Annual Enrollment

Unless you are otherwise notified, your participation in the Plan will continue each Plan Year (unless you change it). However, during Annual Enrollment, you can elect coverage if you previously declined it, or change your coverage level for the following Plan Year.

LEAVE OF ABSENCE

Leave of Absence Without Pay (Employer Contributions to Premiums)

1. A covered Employee who is granted leave of absence without pay due to a service (employment) related injury may continue coverage. The Participant Employer shall continue to pay its portion of health plan premiums for up to 12 months.
2. 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.
3. 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.

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.

Disability

Employees who have been granted a waiver of premium for Basic or Supplemental Life Insurance prior to July 1, 1984 may continue health coverage for the duration of the waiver if the Employee pays the total contribution to the Participant Employer. Disability waivers were discontinued effective July 1, 1984.

Military Leave

Members of the National Guard or of the United States military reserves who are called to active military duty, and who are Plan participating Employees or covered Dependents, will have access to continued coverage under the Plan.

Health Plan Participation - When called to active military duty, covered Employees and covered Dependents may:

1. Continue participation in the Plan during the period of active military service, in which case the Participant Employer may continue to pay its portion of premiums; or
2. Cancel participation in the Plan during the period of active military service, in which case such Plan Participants may apply for reinstatement of coverage within 30 days of:
   a. The date the Employee returns from active duty and is reinstated as an active Employee with a Participant Employer;
   b. The Dependent’s date of discharge from active military duty; or
   c. The date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select; Plan Participants who elect this option and timely apply for reinstatement of Plan coverage will not be subject to a Pre-Existing Condition (PEC) limitation, and the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and any applicable regulatory provisions.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee’s military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage
For leave of absence of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.
For leave of absence of 31 days or more, you may continue coverage for yourself and your Dependents as follows:
   You may continue benefits by paying the required premium to your Employer, until the earliest of the following:
   - 12 months from the last day of employment with the Employer;
   - the day after you fail to return to work; and
   - the date the policy cancels.
   Your Employer may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits
If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the cumulative duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

If your coverage under the Plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

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.

Family and Medical Leave Act (FMLA)

Any provisions of this Plan that provide for: (a) continuation of coverage during a leave of absence; and (b) reinstatement of coverage following a return to Active Employment are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:
Continuation of Health Insurance During Leave
Your coverage will be continued during a leave of absence if:
- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an Eligible Employee under the terms of that Act.
The cost of your coverage during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave
Upon your return to Active Employment following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled coverage (health, life or disability) will be reinstated as of the date of your return.

If you do not return to work following an approved FMLA leave, you may be eligible for COBRA continuation coverage as of the date you terminate employment. Please see your local Human Resources Department for details.

If you do not continue coverage under the Plan during your FMLA leave, you may be entitled to re-enroll in the Plan upon your return to work. See the section entitled “Enrollment” for more details.

CONTINUATION RIGHTS UNDER FEDERAL LAW (“COBRA”)

What is COBRA Continuation Coverage?
Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?
For you and your Dependents, COBRA continuation is available for up to 18 months from the last day of the calendar month from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:
- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours to less than Full-Time employment.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the last day of the calendar month from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:
- your death
- your divorce or legal separation, or
- for a Dependent Child, failure to continue to qualify as a Dependent under the Plan

Who can elect COBRA Continuation?
All qualified beneficiaries have independent election rights. A covered Employee or a qualified beneficiary who is the spouse of a covered Employee may elect continuation coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect coverage on behalf of a minor Child. If a qualified beneficiary elects independent COBRA Continuation coverage for himself only, the monthly COBRA premium
for such coverage will be based on the rate for Employee Only COBRA coverage in effect during the period of Continuation coverage. Also, a qualified beneficiary electing COBRA Continuation coverage for himself only will get a new HRA and Remaining Deductible, pro-rated in the manner described in the section entitled “HRA and Remaining Deductible for New Hires” on page 11.

Who is Entitled to COBRA Continuation?

Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent Children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation. The definition includes a Child born to or placed for adoption with a covered employee during the period of COBRA coverage. A Child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan during the covered employee’s period of employment is entitled to the same rights under COBRA as a Dependent Child of the covered employee, regardless of whether that Child would otherwise be considered a Dependent.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent Child, failure to continue to qualify as a Dependent under the Plan.

It is the responsibility of the spouse and/or the Dependent Child to notify the Plan within 60 days of the date COBRA coverage would have terminated.

As an Employee or Retiree, Notice of Certain Qualifying Events Must Be Given

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Participant Employer within 30 calendar days from the end of the month from which any of the following qualifying events occurred:

- Legal divorce
- A Child ceases to qualify as a Dependent under the Plan, or
- Death of an Employee or Retiree
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above.

Also refer to the section titled “Disability Extension” below for additional notice requirements. Notice must be made in writing and must include:

The name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Disability Extension

For purposes of eligibility for continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy, based upon your residual functional capacity, age, education, and work experience.
If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be disabled under Titles II or XVI of the SSA or by the Plan Administrator, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA or the Plan Administrator must determine that the disability would have to have started at some time before the 60th day of COBRA continuation coverage
2. The qualified beneficiary must provide the written determination of disability from the SSA to the Plan Administrator, if applicable, within 60 days of the latest of the date of the disability determination by the SSA, the date of the initial qualifying event or the benefit termination date due to the initial qualifying event; and prior to the end of the 18 month COBRA continuation period. The Plan Administrator, in consultation with consulting medical staff, will make the determination of disability based upon medical evidence, not conclusions, presented by the applicant’s physicians, work history, and other relevant evidence presented by the applicant.

If the SSA or Plan Administrator later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA or the Plan Administrator makes a final determination that the disabled individual is no longer disabled.

All causes for “Termination of COBRA Continuation” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became first enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- the Employer ceases to provide a Group Health Plan for its Employees;
- after electing COBRA continuation coverage, a qualified beneficiary first enrolls in Medicare (Part A, Part B, or both);
  - after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan.

Notification Requirements

Initial Notice
The Plan is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
The Claim Administrator has retained WebTPA as its COBRA Administrator. WebTPA will provide a COBRA continuation election notice to your Dependents within 44 days from the end of the month in which the qualifying event occurred.

**Notice by Participant Employer**

It is the responsibility of the Participant Employer to notify the COBRA Administrator within 30 days of the date coverage would have terminated because of any of the following events; thereafter the COBRA Administrator will notify the Employee within 14 days of his or her right to continue coverage:

- The Participant's employment is terminated either voluntarily or involuntarily;
- The Participant no longer meets the definition of an Employee; or
- Coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at his/her own expense.

Employees terminated for gross misconduct are not eligible for COBRA coverage.

**How to Elect COBRA Continuation Coverage**

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premiums. The notice will also include instructions for electing COBRA continuation coverage. You must notify the COBRA Administrator of your election no later than the election expiration date stated on the COBRA election notice. If a written election notice is required, it must be postmarked no later than the election expiration date stated on the COBRA election notice. If you do not make proper notification by the election expiration date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the election expiration date, you may change your mind as long as you furnish a completed election form before the election expiration date. In the event of a revocation of the waiver or rejection of COBRA coverage, the Plan will require payment of elected coverage retroactive to the date benefits terminated as a result of the qualifying event.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent Children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA.

**How Much Does COBRA Continuation Coverage Cost?**

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the monthly premium charged by the Plan (including both Employer and Employee contributions) for coverage total of a similarly situated Employee or family member. If the 11 month disability extension is applicable, the premium during such extension may not exceed 150% of the monthly premium charged by the Plan (including both employer and employee contributions) for coverage of a similarly situated Employee or family member. For example:

If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150% for disability extension) of the total Employee premium. If the spouse or one Dependent Child alone elects COBRA continuation coverage, they will be charged 102% (or 150% for disability extension) of the Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150% for disability extension) of the total applicable family premium.

**When and How to Pay COBRA Premiums**

*First payment for COBRA continuation*

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election.
(This is the date the election notice is postmarked, if mailed.) If you do not make your first payment within that 45 day period, you will lose all COBRA continuation rights under the Plan.

**Subsequent payments**

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

**Grace periods for subsequent payments**

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the expiration of the grace period, your coverage under the Plan may be cancelled. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

**Acquiring a New Dependent**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. You are responsible for notifying both Ceridian (the Plan’s COBRA Administrator) and the Plan within 30 days of the formal date of marriage, birth, or adoption. After 30 days, your special open enrollment option to add your new dependent expires. However, only your newly acquired Dependent Child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent Children who are not your Children (e.g., stepchildren or Grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

**Other Coverage that May be Available Following Expiration of Continuation Coverage**

In accordance with the federal HIPAA law, the Louisiana Health Plan ("LHP") provides health insurance coverage for certain eligible persons whose COBRA continuation coverage has expired. To apply for LHP HIPAA coverage, your application MUST be postmarked within 63 days of the date on which your COBRA continuation benefits ended. Not all persons whose COBRA continuation coverage has ended will necessarily qualify for HIPAA coverage with LHP. For more information on HIPAA eligibility, premium rates and benefits, access LHP at [www.lahealthplan.org](http://www.lahealthplan.org). You may also contact LHP at (225) 926-6245 or (800) 736-0947, and advise LHP that you are interested in information about the HIPAA Pool.

**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.
COVERED SERVICES

The chart below provides an overview of how Covered Services are paid by the Plan.

<table>
<thead>
<tr>
<th>Covered Services (see list below)</th>
<th>First Choice Provider</th>
<th>In-Network (Aetna ASA or Verity HealthNet)</th>
<th>Out-of-Network (Non-Contracted Providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services</td>
<td>Total Payment from Plan and Member:</td>
<td>HRA payment: 100% of Contract Rate until exhausted</td>
<td>Total Payment from Plan and Member: HRA payment: 100% of Maximum Reimbursable Charge (MRC) until exhausted</td>
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<td>HRA payment: 100% of Contract Rate until exhausted</td>
<td>Member payment: $0</td>
<td>Member payment: (see below)</td>
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<tr>
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<td>Remaining Deductible: not applicable</td>
<td>Remaining Deductible: If HRA exhausted, 100% of MRC up to balance of Remaining Deductible</td>
<td>Remaining Deductible: If HRA exhausted, 100% of MRC up to balance of Remaining Deductible</td>
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<td></td>
<td>Medical Services Co-Insurance: not applicable</td>
<td>Medical Services Co-Insurance: After Deductible is satisfied, 10% of Contract Rate, subject to certain exceptions¹</td>
<td>Medical Services Co-Insurance: After Deductible is satisfied, 30% of MRC, subject to certain exceptions²</td>
</tr>
<tr>
<td></td>
<td>Plan payment for Medical Services 100% after HRA is exhausted</td>
<td>Plan payment for Medical Services After Deductible is satisfied, 90% of Contract Rate, subject to certain exceptions¹</td>
<td>Plan payment for Medical Services After Deductible is satisfied, 70% of MRC, subject to certain exceptions ²</td>
</tr>
</tbody>
</table>

¹ See sections entitled Mental Health and Substance Use Disorder
² See sections below entitled: (i) "Ambulance"; (ii) "Emergency Services"; and (iii) "Urgent Care Services."
<table>
<thead>
<tr>
<th>Prescription Medications (In-Network Pharmacies)</th>
<th>Generic Drugs</th>
<th>Brand-Name Drugs</th>
<th>Specialty Drugs</th>
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<tbody>
<tr>
<td><strong>Total Payment from Plan and Member:</strong></td>
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<td>100% of Cost until exhausted</td>
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<td>100% of Cost until exhausted</td>
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<td><strong>Member payment:</strong></td>
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<td><strong>Remaining Deductible:</strong></td>
<td><strong>Remaining Deductible:</strong></td>
<td><strong>Remaining Deductible:</strong></td>
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<tr>
<td>not applicable</td>
<td>If HRA exhausted, 100% of Cost up to balance of Remaining Deductible</td>
<td>If HRA exhausted, 100% of Cost up to balance of Remaining Deductible</td>
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<tr>
<td><strong>Prescription Drug Co-Payment:</strong></td>
<td><strong>Prescription Drug Co-Payment:</strong></td>
<td><strong>Prescription Drug Co-Payment:</strong></td>
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<tr>
<td>not applicable</td>
<td>After Deductible is satisfied, Co-Payment is $40 per fill, up to 30-days’ supply</td>
<td>After Deductible is satisfied, Co-Payment is $120 per fill, up to 30-days’ supply</td>
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<tr>
<td><strong>Plan Payment for Prescription Medications</strong></td>
<td><strong>Plan Payment for Prescription Medications</strong></td>
<td><strong>Plan Payment for Prescription Medications</strong></td>
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<tr>
<td>100% after HRA is exhausted</td>
<td>100% of Cost after Deductible and Co-Payment are satisfied</td>
<td>100% of Cost after Deductible and Co-Payment are satisfied</td>
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</tr>
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</table>

**Prescription Medications (Out-of-Network Pharmacies)**

**Important Note:**
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 Remaining Deductible and applicable Co-Payment(s), 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.**
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 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.
Covered Services Under the Plan

The Covered Services under the Plan are set forth in the chart below, and are subject to the limitations set forth in this SPD. See the sections entitled “Benefit Limits and Exclusions Under the Plan” on page 61 and “Definitions” on page 84.

Acupuncture

Allergy Injections, Testing and Serum

Ambulance
- Ambulance Services for Out-of-Network Providers are paid at 90% of MRC after the Deductible is met; Member is responsible for any amounts due in excess of the MRC
- Ground transportation licensed to provide basic or advanced life support to the nearest medical facility equipped to treat illness
- Medically Necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse
- Emergency air ambulance
- See also “Emergency and Non-Emergency Transport”

Ambulatory Facility Services
- Outpatient surgery
- Outpatient x-ray and laboratory charges
- Pre-admission testing
- Short-term Rehabilitative Therapy (Physical Therapy, Speech Therapy, and Occupational Therapy), when provider by a licensed therapist
  - Plan Year Maximum is limited to a combined total of 60 days per Plan Year for all therapies

Anesthesia

Blood, Blood Plasma, and Transfusions

Breast Pumps
Breast pumps are covered at 100%, subject to applicable federal law, provided that the member has a prescription for the pump and obtains it from an In-Network provider. 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 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 Reconstruction and Breast Prosthesis, subject to the following limitations:
Charges made for reconstructive surgery following a mastectomy; benefits include:
- Surgical services for reconstruction of the breast on which surgery was performed
- Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance
- Postoperative breast prostheses
- Mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.
- During all stages of mastectomy, treatment of physical complications, including lymphedema
<table>
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<tr>
<th>Therapy, are covered</th>
<th>Breast reduction when deemed medically necessary</th>
</tr>
</thead>
</table>

**Cardiac Rehabilitation**

**Chemotherapy**

**Chiropractic Care**

**Cochlear Implants**

**Contraception** – see Family Planning

**Circumcision**

**Dental Care**, limited only to the following:
- Excision of one or more impacted teeth as performed by a doctor of dental surgery (D.D.S.) or a doctor of dental medicine (D.M.D.) while coverage is in force
- 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
- Repair within 90 days and completed within 24 months of accidental injuries to sound, natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan

**Diabetic Services, subject to the following:**
- 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

**Dialysis**

**Digital Retinal Imaging**

**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 (pre-determination by Plan Medical Management is encouraged):
- 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

**Emergency and Non-Emergency Transport**, subject to the following:
- Emergency Ambulance Services are paid at 90% of MRC for all Out-of-Network Providers after the Deductible is met; Member is responsible for any amounts due in excess of the MRC.
- Ground transportation licensed to provide basic or advanced life support to the nearest medical facility equipped to treat the emergent Illness or Injury.
- Emergency air ambulance will be covered when it is the only acceptable means of transporting the patient.
- Prearranged or scheduled air or ground ambulance, or non-emergency transportation, when Medically Necessary.

**Emergency Services**

- Emergency Services for Out-of-Network Providers are paid at 90% of MRC after the Deductible is met; Member is responsible for any amounts due in excess of the MRC.

**Warning**
The fact that a hospital or other facility is an 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.

**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%, with no cost to the member and no need to use your HRA dollars, as long as you use an In-Network provider and/or pharmacy (as applicable):
  - Diaphragms/Cervical Caps
  - Generic hormonal contraceptives
  - Generic emergency contraceptives
  - Implantable medications
  - Intrauterine contraceptives

**Genetic Testing**, subject to the following:

- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome.
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered:
  - When either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

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.

**Hearing Aids**, subject to the following:

Whether external or implantable or any related expenses, except that 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 and an audiological evaluation medically appropriate to the age of the Child, if applicable, but this benefit will be limited to a maximum of $2,400.00 per hearing aid per impaired ear every 36 months.

**Home Healthcare**, subject to the following:

Plan Year Maximum: Limited to 180 visits combined (First Choice, In-Network, Out-of-Network). The
Plan pays for Covered Expenses for treatment of a disease or injury in the patient’s home instead of a Hospital or Skilled Nursing Facility. The charge must be made by a “Home Health Agency.” Home healthcare must be prescribed by a Physician and given under a “home healthcare plan” in the patient’s home. Coverage is limited to 180 visits in a Plan Year by a home healthcare professional. One visit is equal to four consecutive hours in a 24 hour period. Custodial care is not covered.

The Plan covers the following home healthcare expenses (up to the Plan maximums):
- Part-time or occasional care by a licensed nurse
- Intermittent home health aide services
- Services of a medical social worker
- Physical, occupational, speech and inhalation therapy
- Medical supplies and medicines prescribed by a physician
- Services of a nutritionist

The Plan does not cover services provided by a person who usually lives with you, or is a member of your or your spouse’s family, or transportation costs.

**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:
  - Train you or your caregiver
  - Monitor the home infusion therapy
  - Provide emergency care
  - Handle collection, analysis and reporting of lab tests to monitor response to home infusion therapy, enteral feedings
  - Provide other eligible home health supplies and services during home infusion therapy

**Hospice**

**Hospital Services**, including:
- Inpatient Hospital - Facility Services
  - Semi-private room and board for hospital stays, includes the following:
    - Intensive Care Unit for Hospital stays, and alternative care settings (private rooms are covered only if Medically Necessary)
    - Special Care Units (ICU/CCU)
    - Nursing care, drugs and medicines, x-rays and laboratory tests
    - Hospital charges for use of its surgical room on an outpatient basis
- Outpatient Facility Services (see also Ambulatory Facility Services)
  - Outpatient surgery
  - Outpatient x-ray and laboratory charges
  - Pre-admission testing
  - Short-term Rehabilitative Therapy (Physical Therapy, Speech Therapy, and Occupational Therapy), when provider by a licensed therapist
    - Plan Year Maximum is limited to a combined total of 60 days per Plan Year for all therapies

**Warning**
The fact that a hospital or other facility is an 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

**Infertility Treatment Services**, subject to the following limitations:
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 Plan payments.

- **Infertility Treatment Services include:**
  - 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
  - Infertility medications for the following indications (lifetime maximum for infertility medications is $10,000):
    - Treatment for infertility, endometriosis, uterine leiomyomata (fibroids)

**Inhalation Therapy**, subject to the following:
- Provided by a registered or licensed therapist when needed to correct a functional disorder due to an illness or injury

**Injections**, including:
- Gardasil
- Rhogam
- Synagis

**Laboratory and Radiology Services** (includes pre-admission testing)

**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.

**Low Protein Food Products**

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

**Mammography**

**Massage Therapy**, when provided by a licensed massage therapist and when determined to be Medically Necessary

**Maternity Care**, subject to the following:
- Including services and supplies provided by a Birthing Center or Certified Nurse Midwife/Certified Professional Midwife (CNM, CPM) for Employee and covered Dependent spouse
- The Plan does not provide maternity care coverage for your Dependent Children

**Medical Supplies**

**Mental Healthcare and Substance Use Disorder Treatment Benefits (including Autism Spectrum Disorder)**

*Mental Healthcare*
The Plan covers consultation, diagnosis or treatment of any mental/nervous condition when services are provided by a:
- Hospital
- Physician
- Licensed Consulting Psychologist (LCP)
- Psychiatrist
• Licensed Psychologist (LP)
• Licensed Social Worker
• Mental health professional

All care must be provided by licensed, eligible Providers—such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, Physicians and qualified Employees of the centers or facilities) for outpatient care.

Mental Healthcare benefits are in parity with Plan medical benefits.

Mental Health Services
Inpatient Mental Health Services
• Services that are provided by a Hospital while you or your Dependent is confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services
• Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Mental Health conditions.
• Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.
• A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Mental Health Intensive Outpatient Therapy Program
• A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Outpatient Mental Health Services
• Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program.

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**

The provider must be licensed or approved by the state in which the services are provided. All care must be provided by licensed, eligible Providers—such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified Employees of the centers or facilities) for outpatient care.

Substance Use Disorder Treatment benefits are in parity with Plan medical benefits

**Substance Use Disorder Rehabilitation Services**

**Inpatient Substance Use Disorder Rehabilitation Services**

- Services provided for rehabilitation, while you or your Dependent is confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Partial Hospitalization sessions and Residential Treatment services.

**Substance Use Disorder Residential Treatment Services**

- Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub acute Substance Use Disorder conditions.
- Substance Use Disorder Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.
- A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

**Outpatient Substance Use Disorder Rehabilitation Services**

- Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Intensive Outpatient Therapy Program.
- A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy.

**Nutritionists**, subject to the limitations set forth below:

- When required to treat a medical condition (charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease)

**Organ, Bone Marrow, and Tissue Transplants**

**All transplant services must be pre-approved.**

Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient’s medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement.

Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants:

- Allogeneic and syngeneic bone marrow/stem cell
- Autologous bone marrow/stem cell
- Cornea
- Heart/lung
- Kidney/pancreas for a diabetic with end stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired
- Liver
- Lung
- Pancreas or intestine which includes small bowel, liver or multiple viscera

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.

Transplant services, including cornea, are payable at Plan benefit levels.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic and syngeneic bone transplants are also covered.

Transplant Travel Services
Charges made for reasonable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered, up to $10,000 per transplant, subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated Center of Excellence. The term recipient is defined to include a person receiving authorized transplant related services during any of the following:
   a) Evaluation
   b) Candidacy
   c) Transplant event
   d) Post-transplant care

Travel expenses for the person receiving the transplant will 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); 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.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available when the Member is a donor.

Orthoses and Orthotic Devices (includes splints and braces)
- Coverage is provided for preparation, fitting and basic additions (such as bars and joints) for the following when found to be medically necessary:
  o Rigid and semi-rigid custom fabricated orthoses
  o Semi-rigid prefabricated and flexible orthoses
  o Rigid prefabricated orthoses
- Custom foot orthoses are covered as follows:
o For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease)
o When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace
o 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, Sickness or congenital defect
o 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.

Oxygen and other gases

Physician’s Services, which includes
- Physician visits
- Inpatient Physician care

Prescription Drug Benefits

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 Express Scripts.

For all medications, only a 30-day supply will be covered at retail pharmacies. You must utilize home delivery for a 90-day supply.

The Plan encourages the use of Generic Drugs. If a Generic Drug is available and you select the Brand Name equivalent, you must pay the difference at the pharmacy between the Generic and Brand Name drug. (This amount will not apply to satisfaction of the Deductible.) This is called an ancillary fee. **If HRA dollars are available at the time you incur an ancillary fee, the HRA dollars will be used to pay the ancillary fee. Please note that any ancillary fees paid from your HRA will NOT apply towards your Deductible.**

Compounded drugs are medications that are formulated by the pharmacist. Often times, 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 Express Scripts, Inc., the Pharmacy Benefit Manager. If the compounded medication is not FDA approved, you will not be reimbursed.

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.

**Where to Call for In-Network Pharmacies and Claim Reimbursement Forms**

Most pharmacies participate in the network. To find a pharmacy near you, or to request a claim reimbursement form call the Pharmacy Benefit Manager at 1-855-346-LSU1 or visit www.lsufirst.org.

Your prescriptions can be filled through a retail pharmacy or through mail order services. It is important to know that not every drug is available with your Plan ID card through the pharmacy.

**Select Home Delivery**

Select Home Delivery encourages Members to fill their maintenance medications using the ESI Mail Order Pharmacy. Home Delivery allows a 90-days’ supply to be shipped directly to the Member’s
home, and orders can be managed online or over the phone directly with ESI. If a Member’s maintenance medications are included in this program, ESI will contact the Member directly regarding this program. If a Member is contacted, the Member will need to make an ACTIVE CHOICE either to participate in Home Delivery or to decline and continue to fill those prescriptions at a retail pharmacy. A Member will be able to fill his maintenance medication(s) at a retail pharmacy two times during the Plan Year before responding to ESI. After the second fill, if a Member has not responded to ESI, maintenance medications included in this program will not be covered under the terms of the Plan.

Prior Authorization
Some medications require pre-authorization in order to be covered by the Plan. In such cases, ESI will alert the retail pharmacist or the Member’s physician that a prior authorization process must be completed.

Drug Quantity Management
This program helps ensure that Prescription Drugs are dispensed in accordance with FDA-approved dosage guidelines. For example, if a Member receives two monthly prescriptions for a low dose of one medication, he could instead receive one monthly prescription at a higher dose for treatment for an equivalent clinical effect. If a Member is identified through this program, the pharmacist will be alerted and may discuss other possible dosage options with you and your physician.

Step Therapy
In some cases, Generic and/or lower-cost Brand Name Drugs may provide the same safe, clinically effective treatment as a more expensive Brand Name Drug. In cases such as this, the Plan will not cover the more expensive Brand Name Drug unless your doctor has demonstrated a clinical need for the more expensive Brand Name Drug.

Specialty/Injectable Drugs Through CuraScript
The Plan utilizes CuraScript, Express Scripts’ specialty pharmacy. Members will be allowed one fill at retail before being required to begin using CuraScript for all specialty medications needs. Benefits include:

- Access to Specialty Experts dedicated to serving you with a higher level of personal care at substantial savings
- Medical Management Programs to help insure you’re taking Medically Necessary and appropriate medications correctly and to provide the support you need to manage your condition
  - Patient care coordinators who will provide comprehensive clinical management services
  - Supplies for administering your medications- such as syringes, needles, and alcohol swabs
  - To receive your next supply of specialty medication through CuraScript, call toll free 1.866.848.9870 (Monday-Friday 7 a.m. to 8 p.m. CST and Saturday 8 a.m. to 12 p.m.)

Prescription Drug Benefit Exclusions
Please refer to the Exclusions section of this document on page 69 for additional exclusions and limitations on the prescription drug benefit.

Preventive Care/Wellness; see also Family Planning Services on page 41 and Women’s Preventive Health on page 53

The Plan covers certain services at 100% when you utilize a First Choice Provider or In-Network Provider/Facility. This means that your HRA dollars will not be used, and you will not be responsible for any Remaining Deductible, Co-Insurance or Co-Payments. If you receive services from an Out-of-Network Provider, you may be responsible for the difference between the billed amount and the Maximum Reimbursable Charge (MRC).
If you have exhausted your Preventive Care benefit, the items or services you had been receiving as Preventive Care may be covered under the section entitled “Covered Expenses,” subject, however, to all exclusions, limitations, and conditions of the Plan, including Medical Necessity.

The Pre-Existing Condition Exclusion does not apply to Preventive Care Services.

Preventive Care Services/Wellness Benefits include:

**Well-Child Care**
- Routine office visits and examinations:
  - Six visits from age 0 – 12 months
  - Three visits age 12 – 36 months
  - Annual visits from age 36 months to age 16 years.
- Immunizations
  - Two doses of Hepatitis A
  - Three doses of Hepatitis B
  - Six doses of Diphtheria, Tetanus, Pertussis (DTaP)
  - Four doses of Haemophilus Influenza type b
  - Four doses of Polio vaccine
  - Six doses of Pneumococcal Conjugate
  - Two doses of Varicella
  - Two doses of Measles, Mumps, Rubella
  - Influenza vaccine (flu shot) one dose each Plan Year for Children over the age of 8 years; two doses (administered separately by at least 4 weeks) each Plan Year for Children up through 8 years of age
  - Human papillomavirus (HPV) vaccine for children ages 9 through 18 years of age at the following intervals:
    - One complete dosage per lifetime consisting of 3 shots given within a 6 month timeframe.
    - Women over the age of 18 years but under the age of 26 years who have not yet received the HPV vaccine may also receive the vaccine.
    - Three doses of Rotavirus Vaccine (Rota Teq) for Children under the age of 1 year
    - Meningococcal conjugated vaccine (MCV4) at the following intervals:
      - One dose between the ages of 11 and 12 years; or
      - One dose before high school entry or at age 15 years, whichever occurs first, for Children who have not previously received the MCV4 vaccine
- Screenings
  - Lead level testing, one between ages 9 to 12 months and one between 12 and 24 months
  - Vision screening conducted at time of well-Child visit at ages 3, 4, 5, 6, 8, 10, 12, and 15 years
  - Hearing screening conducted at time of well-Child visit at ages 4, 5, 6, 8, 10, 12, and 15 years
  - Pap Smear and Routine Pelvic Exam once per Plan Year, as appropriate by age

**Well-Adult Care**
- Routine Exams and Office Visits
  - One visit every 3 years from age 16 to age 40 years for men
  - Fours visits every 3 years from age 16 to age 40 years for women
  - One visit every 2 years from age 40 to age 50 years for men
  - Three visits every 2 years from age 40 to age 50 years for women
  - Annual visits from age 50+ years for men
  - Two visits annually from age 50+ for women
  - Well-woman visit annually in addition to the annual exam schedule above.
- Immunizations
  - Tetanus / Diphtheria (Td) Booster once every 10 years
  - Tetanus, diphtheria, and acellular pertussis (Tdap) may substitute one dose of (Tdap)
for (Td) for persons age 18 years up to age 65 years;
- Influenza Vaccination (flu shot) annually
- Pneumococcal Vaccination (Pneumovax) one dose for persons 65 years and over
- Meningococcal conjugated vaccine (MCV4), one dose for college freshmen living in dormitories
- Shingles vaccine, for persons 60 years and older. Seasonal Vaccinations Administered “in-pharmacy” at ESI Participating Pharmacies

- Screenings
  - Routine annual eye exam
    - Digital retinal imaging, as a component of a routine annual eye exam, is covered 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.
    - Refractions are covered under the Plan, but not covered according to wellness benefits.
  - Cholesterol screening including triglycerides, LDL, HDL, annually for men age 35 years and over and women age 45 years and older
  - Mammograms, as set forth below:
    - a single baseline mammogram for women ages 35 through 39;
    - a mammogram every 24 months for women ages 40 through 49, or more frequently, if recommended by a physician;
    - one mammogram every 12 months for women age 50 or older.
  - Pap Smear and Routine Pelvic Exam once per Plan Year, as appropriate by age
  - Bone density test annually for osteoporosis for women age 50 years and over
  - Colorectal Cancer Screenings as shown below:
    - Fecal occult blood test (FOBT) one test each Plan Year for persons age 50 years and older;
    - Digital rectal examination (DRE) and prostate specific antigen (PSA) test, one per Plan Year for persons age 40 years and older;
    - Colonoscopy once every 10 years beginning at age 50 years;
    - Flexible sigmoidoscopy once every 5 years for persons age 50 years and older; in combination with a double contrast barium enema (DCBE) once every five years for persons age 50 years and older;

Seasonal Vaccinations Administered "in-pharmacy" at ESI Participating Pharmacies

Seasonal influenza and pneumonia vaccinations are Covered Services under the Plan. In addition, Seasonal 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 ESI participating pharmacies. Members will not pay anything out-of-pocket for Seasonal Vaccines provided the vaccinations are received at an ESI Participating Pharmacy and in accordance with the Preventive Care/Wellness benefit.

For more information about Preventive Care and wellness-related products, visit www.lsufirst.org and click on the "My Accounts” tab and then on the webtpa.com icon.

Prosthetics, External

- External Prosthetics (includes prostheses/prosthetic appliances and devices), subject to the following:
  - Available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect
  - Initial purchase and fitting of External Prosthetic Appliances and devices
  - Coverage is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician
- Coverage for replacement is limited to the following:
  - Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- No more than once every 24 months for Members 19 years of age and older
- No more than once every 12 months for Members 18 years of age and under.
- Replacement due to a surgical alteration or revision of the site.

**Pulmonary Rehabilitation**

**Radiation Therapy**, including x-ray and radio isotope 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
- Cosmetic or reconstructive surgery to repair a Dependent Child’s congenital or developmental defect.

**Rehabilitation Hospital and Sub-Acute Facility**
- Plan Year Maximum: Limited to total of 90 days per Plan Year regardless of the Provider’s network status

The Plan pays up to the benefits shown in the table entitled “Covered Expense” above while the patient is confined as a bed patient in a rehabilitation hospital or a sub-acute facility 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. Benefits are limited to 90 days per Plan Year of inpatient care.

**Short-term Rehabilitative Therapy** (Physical Therapy, Speech Therapy, and Occupational Therapy), when provider by a licensed therapist
- Plan Year Maximum: Limited to a combined total of 60 days per Plan Year for all therapies

Short-term Rehabilitative Therapy, subject to the following:

- Charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitations apply to Short-term Rehabilitative Therapy and Chiropractic Care Services:
- Services are not covered if they are custodial, instructional, or educational.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.
**Skilled Nursing Facility**, subject to the following:
- Plan Year Maximum: Limited to total of 120 days per Plan Year, regardless of the Provider’s network status

The Plan pays up to the benefits shown in the table entitled “Covered Expense” while the patient is confined as a bed patient in a Skilled Nursing facility 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.

**Speech Therapy**
- To restore speech lost due to a congenital condition for which corrective surgery cannot be performed due to injury or illness

**Surgical care**
- If two or more surgical procedures are performed through the same incision or in the same operative field, the Plan will pay up to 100% of the major procedure and 50% of each additional procedure.
- If more than one procedure is performed through separate incisions, the Plan will pay up to 100% of the major procedure and 50% for each additional procedure.
- No additional payment will be made for an incidental procedure performed through the same incision.

**TMJD/ TMJS Surgical and Non-Surgical**
- Covered based on medical necessity. Orthodontic treatment is excluded. Appliances are covered when deemed medically necessary by Plan Medical Management.

**Urgent Care Services**
- Urgent Care Services for Out-of-Network Providers are paid at 90% of MRC.

**Warning:** The fact that a hospital or other facility is an 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.

**Virtual colonoscopy**, subject to the following:
- When performed in connection with diagnostic testing only

**Wigs**, subject to the following:
- When needed for hair loss due to cancer or alopecia areata

**Women’s Preventive Health;** see also Preventive Care/Wellness on page 49

The Plan covers certain Women’s Preventive Health Services at 100% when you utilize a First Choice Provider or In-Network Provider/Facility with no Remaining Deductible (your portion of the Deductible) to satisfy and no need to use your HRA. If you receive services from an Out-of-Network Provider, you may be responsible for the difference between the billed amount and the Maximum Reimbursable Charge (MRC).

If you have exhausted your Preventive Care benefit, the items or services you had been receiving as Preventive Care may be covered under the section entitled “Covered Expenses,” subject, however, to all exclusions, limitations, and conditions of the Plan, including Medical Necessity.
**Additional Plan Benefits**

### Critical Illness Direct Cash Benefit

The Critical Illness Direct Cash Benefit provides a direct cash payment when an Employee suffers a Covered Critical Illness. This Critical Illness Direct Cash Benefit is made available to all Employees as a part of the Plan. This benefit may be considered taxable income. The Plan will not issue IRS Form 1099 to Members who receive this benefit; this is a self-reported benefit. You should consult a tax professional to determine whether this benefit is taxable income to you. For more information, contact your Human Resources Management Department.

**Covered Critical Illness:** requires payment of at least $5,000 in Covered Expenses (includes amounts paid by the Plan and/or you) after diagnosis that is related to one of the illnesses set forth below:

1. Myocardial infarction (Heart Attack)
2. Stroke
3. Major Organ Transplant
4. Renal Failure (End Stage)
5. Invasive Cancer
6. Coronary Artery Bypass Surgery

Employees diagnosed with a Covered Critical Illness will receive direct payment from the Claim Administrator upon:

1. Submission of the necessary claim forms to the Claims Administrator within 365 days of the initial diagnosis; and
2. Approval by the Claim Administrator that the financial threshold has been met; and
3. Approval by the Claim Administrator that the Member was Eligible at the time of the diagnosis; and
4. That the diagnosis has been determined to be a Covered Critical Illness by Plan Medical Management

This payment is to assist Employees who have suffered a Covered Critical Illness. Unlike most programs that offer a one-time reimbursement, the Critical Illness Direct Cash Benefit has an Additional Occurrence Benefit and a Reoccurrence Benefit.

- **Principal (Face) Amount Employee Benefit:** $5,000

Only Employees are eligible for the Critical Illness Direct Cash Benefit. The Critical Illness Direct Cash Benefit is not available for spouses or Dependents of Employees.

#### Additional Occurrence and Re-Occurrence Benefit

If an Employee receives payment for a Covered Critical Illness and is later diagnosed with another Covered Critical Illness, the full benefit amount will be paid for the additional Covered Critical Illness following the same approval procedure outlined above.

If you are re-diagnosed with the same condition, the benefit will be paid again in the event the re-occurrence is at least 12 months after the previous illness.

To qualify for payment of an Additional Occurrence Benefit, the Critical Illness must be medically unrelated, as determined by the Plan Administrator, to the Critical Illness that was the basis for payment of the First Diagnosis Benefit.

To qualify for payment of a Re-occurrence Benefit, a period of twelve (12) months must separate the diagnosis of the Critical Illness that was the basis for payment of the First Diagnosis Benefit from the diagnosis of the Critical Illness that is the basis for the Re-occurrence Benefit.
Schedule of Covered Critical Illness Benefits

<table>
<thead>
<tr>
<th></th>
<th>First Diagnosis Benefit</th>
<th>Re-occurrence Benefit</th>
<th>Additional Occurrence Benefit</th>
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<tbody>
<tr>
<td>Invasive Cancer</td>
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<tr>
<td>Myocardial Infarction</td>
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<tr>
<td>Kidney (Renal) Failure</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Organ Transplant</td>
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<tr>
<td>Coronary Artery Bypass Surgery</td>
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</table>

Payment of benefits upon the first Diagnosis of a Covered Critical Illness listed above is subject to the following:

1. The Diagnosis is made within the United States
2. The Diagnosis is made while the Employee’s coverage is in force under the Plan
3. Payment is not precluded by any general or specific exclusion or limitation set forth in this Summary Plan Description or any failure to meet any condition precedent set out below
4. Requires payment of at least $5,000 in Covered Expenses after diagnosis that is related to a Covered Critical Illness

First Diagnosis – If an Employee is first diagnosed with a Critical Illness, defined above, after the Coverage Effective Date, the Plan will pay the Benefit Amount for the Critical Illness shown in the table above.

Re-occurrence – If more than 12 months has passed since the first Diagnosis was made for a covered Critical Illness, and the Employee is diagnosed as having had a subsequent and identical Critical Illness as the First Diagnosis, the Plan will pay the Re-occurrence Benefit Amount for the Critical Illness shown in the table above.

All Covered Critical Illnesses
The Plan reserves the right to have any Covered Critical Illness Diagnosis reviewed by a Physician of its choosing. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Plan shall have the right to request an examination of either the Employee or the evidence used in arriving at such Diagnosis by an independent acknowledged expert selected by the Plan in the applicable field of medicine.

The opinion of such expert as to such Diagnosis shall be binding on both the Employee and the Plan.

Invasive Cancer
The Diagnosis of Invasive Cancer must be positively Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology, upon the basis of a microscopic examination of fixed tissues, or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue and/or specimen. Clinical Diagnosis alone does not meet this standard.

Myocardial Infarction
The Diagnosis of Myocardial Infarction must be based on an event which contains all of the following criteria: (1) associated new electrocardiographic (EKG) changes which support the Diagnosis; (2) concurrent diagnostic elevation of cardiac enzymes above normal levels; and (3) confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Kidney (Renal) Failure
The Diagnosis of End Stage Renal Disease must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.
**Stroke**
The Diagnosis of Stroke must be made by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

**Major Organ Transplant** includes only the following:
- Allogeneic and syngeneic bone marrow/stem cell
- Autologous bone marrow/stem cell
- Heart and/or lung
- Kidney and/or pancreas
- Liver
- Intestine which includes small bowel, or multiple viscera

**Coronary Artery Bypass Surgery**
The following are required:
1. A diagnosis of coronary artery disease, atherosclerosis and/or Heart Attack; and
2. At least one approved procedural code for CABG (coronary artery bypass surgery) as outlined in the approved codes for the Supplemental Critical Illness Benefit; and
3. There is no minimal number of grafts required for payment of this benefit.

**Claim Forms**
Claim forms will be available on [www.jsufirst.org](http://www.jsufirst.org) under the “Forms” tab. Completed claim forms must be sent to WebTPA within 365 days of the date of diagnosis at the address set forth below. Submit your claims to:

WebTPA PO Box 99906 Grapevine, TX 76099-9706WebMD/Envoy Payer ID #75261

**Payment of Claims**
Upon receipt of a properly completed claim form that is payable under the terms of the Plan, payments will be made to (or on behalf of, if applicable) the Employee suffering the loss. If an Employee dies before all payments due have been made, any amounts still payable under this benefit will be paid to the estate of the Employee.

Any payment WebTPA makes in good faith fully discharges the Plan’s liability to the extent of the payment made. WebTPA may require any and all payees to execute releases acknowledging discharge of the Plan’s liability under this benefit.

**Physical Examination and Autopsy**
The Plan at its own expense has the right and opportunity to examine any individual whose loss is the basis of claim under the Plan when and as often as it may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

**Employee Assistance Program (EAP)**
These benefits provide coverage for confidential and convenient access for assessment, referral and/or short term problem resolution sessions for Clinical Services. In case of an emergency, immediate crisis intervention is available on a 24 hour basis. See EAP Clinical Services section below for more details.

**EAP Certification Requirements For You and Your Dependents**
You or your Dependent must request referrals for any treatment for Employee Assistance Program Clinical Services while not confined in a Hospital. A referral must be requested by you or your Dependent prior to the treatment.

EAP expenses incurred for benefits under this Plan will not include expenses incurred while you or your Dependents are Confined in a Hospital.

**EAP Covered Expenses**
EAP Covered Expenses for Out-of-Network Providers are limited to the Maximum Reimbursable Charge (MRC) for the items or services furnished, as determined by the Plan, in accordance with the section entitled “Maximum Reimbursable Charge” on page 61.
EAP Clinical Services

If a Member incurs EAP Covered Expenses for short-term problem resolution sessions in connection with Mental Health or Substance Use Disorder and/or Behavioral issues, the amount payable under the EAP is outlined as follows, subject to all other Plan provisions, and as set forth herein.

The percentage payable will be as follows:
100% of the EAP Covered Expenses incurred for EAP network treatment for short-term problem resolution sessions in connection with behavioral concerns and/or Mental Health or Substance Use Disorder while the person is not confined in a Hospital.

No EAP benefits are payable for expenses incurred for short-term problem resolution sessions in connection with Mental Health or Substance Use Disorder unless those resolution sessions are received from, or arranged by, EAP Participating Providers and the EAP National Care Center has been notified.

EAP Clinical Services Schedule

These benefits provide coverage for confidential and convenient access for assessment, referral and/or short term problem resolution sessions for EAP Clinical Services.

In case of an emergency, immediate crisis intervention is available on a 24 hour basis.

Maximum EAP Benefits For You and Your Dependents This Plan Will Pay:
- Outpatient Care, up to 3 visits per presenting issue.

For EAP Clinical Services, contact the Employee Assistance Program for information on providers in your area, and to notify of your selection. In an EAP Clinical Services emergency, trained clinicians shall be available at the EAP National Care Center to telephonically address the situation and to make a referral to a local counselor or crisis intervention center for assessment, referral and/or short term problem resolution.

After the 3 EAP sessions have been utilized, you may be eligible to continue your treatment plan through the mental health provisions of the medical benefit program of the Plan in which you and your Dependents are currently enrolled.

Confidentiality is maintained except for a few situations in which information may be disclosed. For example, various situations, such as where the life and/or safety of an individual is seriously threatened or if the disclosure is required by law are exceptions to confidentiality rules. In all other instances, confidentiality rules will apply unless a release of information has been signed by the member.

EAP Clinical Services Maximums

The total number of EAP sessions for benefits payable for each occurrence due to behavioral issues will not exceed the maximum benefit as set forth herein for those causes.

EAP Clinical Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining EAP benefits payable, charges made for the treatment of any physiological conditions related to EAP Clinical Services will not be considered to be EAP Covered Expenses.

Examples of issues for which assessment, referral or short-term EAP counseling sessions are available under the EAP include:

- Relationship difficulties
- Emotional/psychological concerns
- Work or family stress and anxiety
- Alcohol and drug abuse
- Personal and life improvement
Legal or financial topics
Depression
Childcare
Eldercare issues
Grief issues

Legal/Financial services
You can receive legal and financial guidance from qualified professionals, including a free initial consultation for each issue.
* Typical financial matters include credit counseling, debt and budgeting assistance, tax planning, and retirement and college planning.
  * Free online will
  * Telephonic tax consultation
  * Reduced rate for continued services *
  * Detailed wills and trust preparation
  * Identity theft consultation
  * Mediation services
  * Website forms and information
  * Legal and financial library

Telephonic and online Worklife resources
With worklife services, employees and their households can receive assistance for a variety of concerns including childcare, eldercare, adoption, daily living issues and other issues they may encounter.
  * Monthly webinars on various topics
  * Childcare and eldercare searches
  * Public and private school searches
  * Adoption resources
  * Health assessments and tools
  * Health and wellness resources
  * Household services
  * College search and financing tools
  * Veterinarian and pet care searches
  * Over one million worklife providers

**Genetic Information Non-Discrimination Act of 2008 (GINA)**
The Plan may not adjust premium or contribution amounts on the basis of genetic information. The Plan may not require a Plan Member or family member to undergo a genetic test. The Plan may request a Plan Member undergo a genetic test under limited circumstances. Generally, the Plan is prohibited from collecting genetic information regarding its Members.

**Newborns’ and Mothers’ Health Protection Act of 1996**
Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: 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; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in

58
excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Exception: The minimum length of stay provisions shall not apply in any case in which the decision to discharge the mother or her newborn Child prior to these stated minimums is made by an attending provider in consultation with the mother.

MEDICAL MANAGEMENT

Medical Management is intended to improve the effectiveness of health care by monitoring patient treatment plans and working directly with providers and patients to optimize care and the patient understanding of that care. Medical Management is indicated only for patients who have diagnoses which can frequently be optimized through a personal assessment and plan of care. The Medical Management process takes into account the needs of the patient, the recommendations and opinions of the patient’s health care team, and the cost of alternative methods or processes of care. The Medical Management team is multidisciplinary and may include, case managers, complex care support nurses, health coaches, medical directors, social worker, pharmacists and the patient’s health care providers.

Once a patient is determined to be a candidate for Medical Management, the Medical Management team may perform any or all of the following:

- Establish a working relationship with the patient’s providers and other members of the health care team to assess the patient’s needs;
- Provide face-to-face and telephonic outreach to both patients and their treatment team;
- Ongoing communication with the patient’s healthcare team;
- Assessment of current health status;
- Assessment of psychosocial factors which can contribute to health;
- Establishment of patient personal health goals;
- Assistance with accessing community resources or network providers;
- Identify alternatives for treating the patient (these alternatives may be cost effective to both the patient and the plan);
- Education and assessment of adherence to the patient’s physician prescribed treatment plan.
- Make recommendations to the Plan concerning the use of alternative forms of treatment or facilities which are not otherwise covered under the Plan, subject to the limitations hereafter set forth.

Medical Management may recommend to the Plan Administrator the use of alternative forms of treatment or facilities which are not otherwise covered under the Plan (hereafter, “Alternative Treatment”). The Plan Administrator will make this determination based on what is in the best interest of the Plan and the Participant. If the Plan Administrator accepts the recommendations of the Medical Management team, the cost of the Alternative Treatment will be covered under the Plan on the same basis as the items and services for which they are substituted (i.e., subject to the Deductible, coinsurance, and maximum benefit limits). The approval of Alternative Treatment by the Plan Administrator is done on an individual, case-by-case basis, and does not mean that such Alternative Treatment will be approved, covered or paid in other cases, even if recommended by the Medical Management team. The Plan Administrator has sole discretion whether to accept or reject, in whole or in part, the recommendations of the Medical Management team.

All Alternative Treatment should be recommended to and approved by the Plan in advance of receipt of any items or services not otherwise covered.

Case Management

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized
facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program may refer an individual for Case Management.

Each identified patient is assessed to determine the level of Case Management that is appropriate. Case Management staff will reach out to the patients and arrange a date/time for an initial assessment (this may be telephonic or face-to-face). During this initial assessment, Case Managers will work with the patient and caregivers to determine the needs of the patient as well as patient identified health goals. Assessments not only address the patients’ medical concerns, but also concerns related to psychosocial issues such as financial needs, transportation and/or lack of support. Case Managers will also explain, in detail how the program works and that participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient. Case Managers will work with patients and their caregivers to help them understand their doctors recommended treatment plan. Case Managers are advocates for the patient who aim to empower them with knowledge and skills to not only understand their diagnosis and treatment plan, but also assist them in navigating the complex healthcare system.

The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home). The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan). Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient’s needs. While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.
**BENEFIT LIMITS AND EXCLUSIONS UNDER THE PLAN**

**Maximum Reimbursable Charge (MRC)**

The Plan pays 70% of Covered Expenses after the Deductible, up to the “Maximum Reimbursable Charge,” when an Out-Of-Network Provider/Facility is used. Urgent Care Services and Emergency Room Services for Out-of-Network Providers are paid at 90% of MRC. Member is responsible for any amounts due in excess of the MRC.

**Benefit Maximums**

The Benefit Maximum can be met by the number of days a service is covered, or the dollar limit, as applicable.

**Exclusions Under the LSU First Health Plan**

In addition to other limits described herein, the Plan does not cover charges for the treatment, services, and/or supplies hereinafter set forth.

- 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
- Treatment, services or supplies that are not Medically Necessary or usual to the treatment of an illness or injury as determined by the Medical Necessity Review Organization retained by the Plan Administrator to make such determinations. This does not apply to Preventive Care Services or other health care services specifically covered under the Plan that are not required to preserve your health.
- Amounts in excess of any Co-Insurance component limits, except as specified in the section entitled “Covered Expenses”
- Any illness or injury for which benefits or payments are received (or could be received if claims were made) under any worker’s compensation law, Employer’s liability law or similar act
- Any care of military service connected conditions for which an Employee incurred charges while on active duty with the armed services of any country or international organization
- Treatment while confined in a state, federal or Veterans Administration hospital for which charges are not imposed
- Health services needed from attempting to commit or committing a felony, or engaging in an illegal occupation
- Services that are prohibited by law or regulations
- 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)
- Health services performed before the effective date or after the termination of coverage under this Plan
- Any diagnostic inpatient admission if the test can be performed on an outpatient basis
- Any care not recommended and approved by a licensed physician
- Any charges of a physician or health professional for services he or she provides to herself or himself or to any close relative (close relative means spouse, brother, sister, parent, grandparent or Child and the spouse’s brothers, sisters, parents, grandparent or Child)
- Services rendered by anyone other than a covered healthcare provider
- Charges for physician’s services for injections that can be self-administered
- Vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs
- Non-medical counseling or training services
- Services of the clergy
- Services for reversal of sterilization
• Non-emergency admissions more than 24 hours in advance of a procedure unless specified by your physician
• Personal comfort items while hospitalized such as telephone or television; hospital room and board expenses that exceed the semiprivate room rate unless a private room is approved by Plan Medical Management
• Excludes penile and testicular prostheses
• The following are specifically excluded orthoses and orthotic devices:
  o Prefabricated foot orthoses;
  o 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;
  o Copes scoliosis braces
  o Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
  o Arch supports;
  o 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.
  o Orthoses primarily used for cosmetic rather than functional reasons; and
  o Orthoses primarily for improved athletic performance or sports participation.
• Biomechanical evaluation, range of motion measurement and reports, and negative mold foot impression
• Transportation, other than local ambulance service, for a medical emergency to the nearest hospital that can provide care
• Expenses not specifically listed as Covered Expenses under this Plan
• Health professional charges for missed office visits, mailing, shipping and handling expenses, completing any form, or for medical information
• Any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community
• Charges for the treatment of compulsive gambling
• Charges that exceed the allowed amounts and/or the Maximum Reimbursable Charge, except as specifically covered as a HRA Only Covered Expense
• Covered expenses not payable because the applicable Deductible and/or Out-of-Pocket limit has not been met
• Expenses eligible for payment under any other plan, including Medicare
• Sales tax
• Adoption or surrogate expenses
• Ventilator-dependent communication services while confined in a hospital or other medical facility
• Autopsies
• Charges for duplicating and obtaining medical records
• Augmentative communications devices such as keyboards or voice synthesizers in the case of speech impairments
• Breast reduction, unless deemed medically necessary
• Marriage counseling
• Lenses, frames and contact lenses; other fabricated optical devices or related professional services including the treatment of refractive errors such as radial keratotomy and laser refractive surgery regardless of medical condition; except when determined to be Medically Necessary following cataract surgery
• Vision therapy, except in the case of diabetes
• Any dental care, treatment, implants, surgery, or supplies under the medical portion of the Plan, except for the following:
  o Repair within 90 days and completed within 24 months of accidental injuries to sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan.
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.

Excision of one or more impacted teeth as performed by doctor of dental surgery (D.D.S.) or doctor of dental medicine (D.M.D.) while coverage is in force.

For care/treatment rendered as a direct result of radiation therapy to the oral cavity/mucosa, including dental extraction and disposable radiation mouthguard secondary to such radiation therapy.

- Charges for or related to fetal tissue transplants
- Charges related to organ transplants except as specified in the section entitled “Organs, Bone Marrow and Tissue Transplants.”
- 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.
- Services, chemotherapy, supplies, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered
- Charges for cosmetic or reconstructive surgery and related services, except for 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
  - Cosmetic or reconstructive surgery to repair a Dependent Child’s congenital or developmental defect
- Charges for sex transformation surgery, hormones related to the surgery and any related expenses.
- Charges for surgery or treatment of an experimental or investigative nature as determined by the Plan Administrator (this means the medical use of a service or supply that is still under study and that the service or supply is not yet recognized throughout the provider’s profession in the U.S. as safe and effective for the diagnosis and treatment of the illness or injury). This exception includes but is not limited to all phases of clinical trials, all treatment protocols based on or similar to those used in clinical trials; drugs approved by the FDA under its Treatment Investigational New Drug regulation (Note: some investigational services or items in connection with clinical trials may be covered, as required by law. See the section “Legally Required Expenses” for more detail.) This exception does not include drugs that: (a) have been granted treatment investigational new drug (IND) or Group C/treatment IND status; or (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 Plan Administrator.
- 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
- Hypnotism
- Phototherapy devices for Seasonal Affective Disorder
- Gene therapy as a treatment for inherited or acquired disorders
- Services for, or related to, systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not Medically Necessary
- Liposuction
- Full body scans, EBCT (heart scans), except when prescribed for diagnostic rather than preventive or wellness purposes
- Expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling
- Travel and/or lodging expenses of a physician or a patient, except as specified in the organ transplant section
- Products purchased outside of the United States, unless in an unexpected, emergency situation
- Services provided mainly for rest cures, the ease of a household, or sanitarium care
• Custodial care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional
• Services or supplies 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
• Private duty nursing services
• Maternity care for Dependent Children
• Charges incurred for any surgical procedure or non-surgical procedure aimed at alleviating obesity, including morbid obesity. These specific procedures include: a) gastric bypass; b) roux-en-Y; c) duodenal switch; d) laparoscopic lap band; or e) any other new or related procedures done for the purpose of weight reduction to eliminate obesity or the co-morbidities of obesity
• Wig accessories such as:
  o Wig caps, wig stands, brushes, sweat liners, toupee clips, adhesives, shampoos, conditioners, sprays, fresheners, mousses, gels, detanglers, wig tape, wig restorer, etc.
• Enteral feeding formulas, except for the following:
  o Prescription and over the counter enteral feeding formulas when considered a sole source of nutrition and given via a feeding tube. This includes tube feeding supplies; or
  o Oral prescription enteral formulas when considered a sole source of nutrition. Over the counter enteral feeding formulas are not covered when given orally
• The Critical Illness Direct Cash Benefit is subject to the limits described in the Plan and does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:
  o The Employee being under the influence of an excitant, depressant, hallucinogen, narcotic, other drug, or intoxicant unless prescribed by a Physician. This exclusion does not apply if the loss resulted from an act of domestic violence or a medical (including both physical and mental health) condition;
  o Voluntary participation by the Employee in a riot;
  o Any illness, loss or condition specifically excluded from the definition of any Covered Critical Illness;
  o War, whether declared or not
• The Mental Health and Substance Use Disorder Benefits exclude the following:
  o 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
  o Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
  o 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
  o Counseling for activities of an educational nature
  o Counseling for borderline intellectual functioning
  o Counseling for occupational problems
  o Counseling related to consciousness raising
  o Vocational or religious counseling
  o I.Q. testing
  o Custodial care, including but not limited to geriatric day care
  o Psychological testing on Children requested by or for a school system
  o Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline
• Short-term Rehabilitative Therapy and Chiropractic Care services that are not covered include but are not limited to:
**Sensory integration therapy, group therapy; 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**

- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury
- 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

**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

**The following are specifically excluded from Employee Assistance Program Clinical Services:**
- Services provided by a Non-Aetna Behavioral Health (CBH) Network provider
- Services provided by a CBH Network provider who is a member of your family or your Dependent’s family
- Inpatient hospital treatment
- Counseling services beyond a total of 3 sessions per presenting issue for each of you and your Dependents
- Charges for unnecessary care or treatment or in connection with experimental procedures or treatment methods
- Charges for custodial services, education or training
- Counseling required by law or paid for by any workers’ compensation or similar law or by a public program other than Medicaid
- Services received before your participation in the EAP begins
- 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 medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorder or developmental articulation disorders
- Counseling for activities of an educational nature
- Counseling for borderline intellectual functioning
- Counseling related to raising consciousness
- Vocational or religious counseling
- I.Q. testing
- Residential treatment
- 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
- For conditions which are:
  - Within the scope of usual medical practice
  - Normally handled by non-mental health/behavioral health and Substance Use Disorder clinicians
  - For charges in excess of the amount which the Provider has agreed to accept for the service
• The following are specifically excluded from the Infertility Treatment Services Benefit:
  o Reversal of male and female voluntary sterilization
  o Infertility services when the infertility is caused by or related to voluntary sterilization
  o Any experimental, investigational or unproven infertility procedures or therapies

• The following are specifically excluded from the Prescription Drug Benefit (see also “Covered Services Under the Plan” on page 39):
  o Injectable medications administered by a health care Provider (except for insulin and Depo Provera)
  o Immunizations, vaccines, allergy agents for injection, except for shingles vaccines for those 60 and older, pneumonia vaccines, and influenza vaccines (See “Covered Services Under the Plan” on page 39 for more information on items covered under the Medical Benefit)
  o Blood and blood plasma
  o Hearing aids (hearing aids may be covered as a medical item)
  o Non-legend nutritional supplements, except as required for the treatment of PKU (phenylketonuria)
  o Products used at or dispensed at an outpatient or inpatient facility, clinic, or doctor’s office, including hospitals, extended/nursing care homes, home care service, home infusion services
  o Products not approved for use in the United States, experimental therapy, or products purchased outside the United States, unless in an emergency situation
  o Prescription drugs for anyone other than the recipient of the prescription
  o Prescriptions exceeding a reasonable quantity as determined by your Physician in consultation with the Express Scripts, the pharmacy benefits administrator
  o Medical devices or equipment
  o Smoking cessation products
  o Weight loss medications, except as approved through Express Scripts’ Prior Authorization Program
  o Anti-wrinkle medications
  o Hair growth and hair removal treatments
  o De-pigmentation products used for skin conditions requiring a bleaching agent
  o Yohimbine for erectile dysfunction (not FDA approved for this indication)
  o Non-legend medications and OTC equivalents except as approved by the Plan Administrator
  o Durable Medical Equipment, except for:
    o Respiratory Therapy Supplies (e.g. Aerocamper, Spacers, Nebulizers)
    o Non insulin syringes
  o Diagnostic testing and imaging supplies (e.g. Tubersol used for TB skin test, Radiopaque dye for outpatient testing)
  o Homeopathic Drugs (all dosage forms including injectable)
  o 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 Express Scripts, the pharmacy benefits manager.
  o Non-prescription or over the counter medications unless approved by the Plan Administrator

Treatment, services, and/or supplies excluded under the Plan may qualify for recommendation and approval for coverage as Alternative Treatment. Please refer to the section entitled “Medical Management Recommendations”
FILING CLAIMS FOR BENEFITS OTHER THAN CRITICAL ILLNESS DIRECT CASH BENEFITS

When you receive care from your health care 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 under Submitting a Claim, below.

Remember:
By utilizing a First Choice Provider, you incur no Remaining Deductible or Co-Insurance responsibility.
Also, 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 account for the moment in time 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.

All claims must be received by WebTPA within 365 days following the date of service in order to be processed according to the terms of this Plan. All others will be automatically denied payment due to untimely filing.

Submitting a Claim

The following procedures only apply when a Healthcare Provider does not submit a claim on your behalf:

The prompt filing of any required claim form will result in faster payment of your claim. In order to get the required claim form, go to www.lsufirst.org and click on the webtpa.com link. All fully completed claim forms and bills should be sent directly to your servicing Cigna Claim Office.

File your claim forms as described below:

Hospital Confinement
If possible, print your WebTPA Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived. Present your Plan Identification Card at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to WebTPA.

During Hospital Confinement
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.
Doctor's Bills and Other Medical Expenses

Claims should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

Claim Reminders:
Be sure to use your Member ID and account number when you file a claim form, or when you call your WebTPA claim office.

Your Member ID number is the ID shown on your Plan identification card.
Your account number is the 12-digit policy number shown on your Plan ID card.

Send claims to:
WebTPA
P.O. Box 99906
Grapevine, TX 76099-9706
WebMD/Envoy Payer ID #75261

PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.
COORDINATION OF BENEFITS (COB)

If you have healthcare coverage available through another employer or health plan, this section applies to you. For example, you may be covered as a Dependent under your spouse’s medical plan. The “coordination of benefits” provisions prevent duplicating benefit payments when you or your Dependent(s) also have coverage through another group plan. Coordination of benefits also determines which plan pays first.

Note: Special rules apply for coordinating benefits with Medicare. See the section below entitled “Coordination with Medicare.”

How Coordination of Benefits Works

Covered expenses not reimbursed by the primary plan (see below) will first be paid from the applicable component of the Plan.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes, but is not limited to, Medicare (refer to Coordination with Medicare following this section) and Tricare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever names it is called, when not prohibited by law.

Here’s how coordination of benefits works: The first step is to determine which plan is primary and which plan is secondary. The primary plan always pays benefits first. When the Plan is secondary, we determine what we would have paid if Plan were primary. The maximum amount payable is the amount due under the Plan, less the amount paid by the primary plan.

Example of Coordination of Benefits:
Assume the following: your spouse (i) is covered under his or her own employer’s plan; (ii) is your Dependent under the Plan; and (iii) incurs a $100 expense for an office visit. Let’s also assume the Plan considers the allowable expense for the office visit is the full $100. If your spouse’s plan covers the visit at 80% ($80), the Plan will pay $20 ($100 - $80). In this example your total benefit would be a total of $100 ($80 + $20).

Order and Coverage, Employee and Spouse

- If one of the plans does not have a coordination of benefits provision, that plan will pay first.
- If you (or your spouse) are covered as an employee by one plan and as a dependent by another, the plan that covers the person as an employee will pay benefits first. If you or your spouse is also covered by Medicare and are not actively working:
  - The plan that covers a person as a dependent of an employee is primary;
  - Medicare is secondary, and
  - The plan that covers a person as a retired employee pays third.
• If you or your dependent are covered under one plan as an employee and under another plan as a retired or laid off employee, the plan that covers the person as an employee (or a dependent of an employee) is primary.
• If you are covered on two or more plans as an employee, the plan under which you first became eligible for coverage is primary.

**Order of Coverage, Dependents**

For a covered Dependent Child whose parents are not divorced or separated and who is covered as a Dependent under both parents’ plans:
• The plan of the parent whose birthday is first in a calendar year will pay benefits first for the covered Child. For example, if the father’s birthday is in March and the mother’s birthday is in September, the father’s plan is primary for the Child. This is called the “birthday rule.”
• If the parents have the same birthday, the plan that has covered a parent longer will pay benefits first for the Child. For example, if the father has had coverage under his plan for five years and the mother has had coverage under her plan for seven years, the mother’s plan is primary for the Child.
• If the other plan does not use the birthday rule but bases the order of benefits on the gender of the parent so that the plans don’t agree on order, the rules of the other plan will determine which plan pays first.

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.
• The medical plan of the parent who has a court decree of financial responsibility will be primary.
• If no court decree exists:
  o If the parent with custody has not remarried, the medical plan of the custodial parent will be primary.
  o If the parent with custody has remarried, the plan of the custodial parent will be primary, the plan of the step-parent will be secondary, and the plan of the non-custodial parent will be third.

**Coordination with Medicare**

If you keep working for your Employer and you or a covered Dependent becomes eligible for Medicare, the Plan will remain your primary plan and Medicare will be secondary. Once you: (i) retire; and (ii) are Medicare-eligible; and (iii) elect to remain in the Plan, Medicare becomes your primary plan and the Plan will be secondary. Irrespective of any other provision of the Plan, to the extent permitted by law, the Claim Administrator will use the following rules to coordinate benefits when Medicare is primary:

1. The following applies to Retirees and to covered spouses of Retirees who have become Medicare-eligible before July 1, 2009:
   a. A Retiree and/or the Retiree’s spouse may be eligible for Medicare if the Retiree or Retiree’s spouse has sufficient earnings credits.
   b. If the Retiree or Retiree’s spouse did not enroll in Medicare Part B when eligible to do so, the Plan will pay primary as to claims that would otherwise be payable under Part B, provided the employee has paid the applicable premium for Retirees with No Medicare.

2. The following applies to Retirees and to covered spouses of Retirees who have become Medicare-eligible on or after July 1, 2009:
   a. The Claim Administrator will determine the benefits which would have been payable for eligible charges incurred under the terms of the Plan in the absence of Medicare.
   b. The Claim Administrator will deduct the benefits payable for such eligible charges under the provisions of Medicare whether or not you are actually covered by Medicare from the amount which would have been payable under the Plan.
c. The remaining balance, if any, shall be payable under the Plan, subject to the maximum due under the Plan. The Deductible and Co-Insurance provisions, if any, will be applied before benefits are paid on this balance.

d. **Because the Claim Administrator will coordinate benefits for all Retirees eligible for Medicare as if such Retiree were covered under Medicare Part A and Part B, you are strongly encouraged to enroll in Medicare Part A and Part B as soon as you are eligible.**

**Note:**
Retirees who fail to enroll in Medicare Part B when eligible to do so will be subjected to a substantial Medicare premium penalty for Part B coverage to enroll at a later date.

Benefits payable under the Plan shall be determined in the above manner regardless of whether or not the Participant has actually enrolled in Medicare Part A and Part B.

**Right of Recovery**

The Plan has the right to recover from you or your Dependent benefits it has paid on your behalf or your Dependent’s behalf that were:

- Paid in error
- Paid due to a mistake of fact
- Paid prior to meeting the Remaining Deductible portion of the Deductible
- Paid in excess of the Plan's Co-Insurance limits prior to meeting the Co-Insurance Maximum for the Plan Year
- Paid because you or your Dependent misrepresented facts

If the Plan provides a benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be repaid by you, or
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment, specifically including, without limitation, reduction of the amount allocated to you or your Dependent’s HRA in any new Plan Year.

If the Claim Administrator determines that a claim or benefit has been paid in error, it will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover claims improperly paid or benefits improperly advanced by taking any or all of the following actions:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan
- Reducing the amount allocated to your HRA in any given Plan Year by the amount you or a covered Dependent owe for any advancement of benefits in any previous Plan Year; however, your HRA balance will not be reduced to a negative balance

The Plan reserves the right to pursue any other means or methods of collection of any amounts owed to the Plan permitted by law.

**Third Party Liability**

In situations where a third party (person or organization) is responsible for your or a covered Dependent’s illness or injury (for example, injuries caused by a car accident or on someone’s property), and the Plan has exercised its right to Subrogation, the Plan has the right to:

- Pursue all rights of recovery against the third party or your insurance carrier (in case of a claim under an auto insurance policy)
• Obtain from you any amount received by judgment, settlement, or otherwise from the third party, your insurance carrier or any other person or entity (including the auto insurance carrier), up to the amount paid by the Plan as a result of such illness or injury.

If you believe a third party is at fault for an injury or illness, you must notify the Claim Administrator. You (or, if you are not legally capable, your legal representative) are responsible for providing the information, assistance and/or documents to help the Plan obtain the rights under this provision.

**Subrogation**

The Plan has a right to recover, by way of subrogation or right of reimbursement, any expenses paid on your or your dependents’ behalf for which another policy or individual is legally responsible. ‘You’ includes any person receiving benefits under the Plan including all dependents.

The Plan has the right to recover any payments you receive from any third party’s liability, including but not limited to

1. any person alleged to have caused you to suffer injuries or damages,
2. other insurance covering the third party, as well any first party coverage including but not limited to any payments you receive from your own personal injury protection (PIP), med-pay, uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, or school insurance, workers compensation insurance or whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions. The benefits under this plan are secondary to any coverage or any other applicable insurance.

You agree as follows:

• To assign to the Plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits provided, plus reasonable costs of collection.
• To cooperate with the Plan in protecting its legal rights to subrogation and reimbursement.
• That the Plan’s rights will be considered as the first priority claim against third parties, to be paid before any other of your claims are paid.
• That you will do nothing to prejudice the Plan’s rights under this provision, either before or after the need for services or benefits under the plan.
• That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name.
• Unless prohibited by State Law, the Plan may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the plan, regardless of whether or not you have been fully compensated and regardless of whether the payments you receive make you whole.
• To hold in trust for the Plan’s benefit under these subrogation provisions, any proceeds of settlement or judgment.
• That the Plan shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
• That you will not accept any settlement that does not fully compensate or reimburse the Plan without the Plan’s written approval.
• To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the Plan may reasonably request from you.
• If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan.
  1. If the amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
• In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan’s lien from any future benefit under the Plan.
• The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
• The Plan will not pay fees, costs, or expenses you incur with any claim or lawsuit, without our prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

The Plan will not pay fees, costs, or expenses you incur with any claim or lawsuit, without our prior written consent.

**Priority of Recovery**

After exercising its rights of subrogation, the Plan’s right of recovery will not apply until the covered person has been made whole for the loss. The recovery provided for under this provision will not be reduced on account of any costs or attorneys’ fees, and neither the Plan nor the Plan Administrator shall be liable for such costs or fees, unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion. The Plan also reserves the right to independently pursue and recover paid benefits.
MEDICAL NECESSITY DETERMINATIONS AND APPEALS

Prospective Review

Initial Determinations of Medical Necessity is required as part of the Pre-Authorization process. You and/or your provider should contact the MNRO at the time needed services, supplies, drugs or treatment are identified. Once requests have been reviewed and a determination has been made, you and your provider will be notified (by the MNRO) of the MNRO’s decision. If the prospective review by the MNRO reveals that the supplies, services, drugs or treatment are not Medically Necessary, no benefits for such supplies, services, drugs or treatment will be payable under this Plan. If you elect to continue with the hospitalization, course of treatment, level of care or supplies, services, drugs or treatment after you have been notified that the MNRO has determined that it is not Medically Necessary, you (not the Plan) will be responsible for all charges for such supplies, services, drugs or treatment. See Appeals/External Review for more information on services deemed not medically necessary and member recourse.

Prospective Reviews are generally be made within 2 working days of obtaining the appropriate medical information, but in no event shall be made more than 30 days from the receipt of the request, unless an extension of time has been agreed to by your physician or authorized representative.

The MNRO will notify the provider and/or the member of its decision within 1 working day of the decision, and shall provide documented confirmation of the decision within 2 working days of the decision.

Concurrent Review

During the course of a hospital stay or course of treatment, the Plan will utilize the assistance of the MNRO to obtain a determination of whether supplies, services, drugs or treatment, continued hospitalization, or level of care is Medically Necessary (concurrent review). If the MNRO should determine that hospitalization, course of treatment, level of care or supplies, services, drugs or treatment are no longer Medically Necessary, you and/or your provider will be notified of that decision. If you elect to continue with the hospitalization, course of treatment, level of care or supply or service after you have been notified that the MNRO has determined that it is not Medically Necessary, you (not the Plan) will be responsible for all charges for such supplies, services, drugs or treatment. See Appeals/External Review for more information on services deemed not medically necessary and member recourse.

The MNRO will make concurrent review determinations within one (1) working day of receipt of all appropriate medical information.

The MNRO will notify the provider and/or the member of its decision within one (1) working day of making the concurrent review determination. The MNRO will provide documented confirmation of its decision to the provider within one (1) working day of the notification.

Services for which concurrent review has been requested will be payable by the Plan (subject to the terms of the Plan other than Medical Necessity) until the provider has been notified of an adverse determination. You will not be liable for services after notification to the provider until you have been notified of the adverse determination.

A copy or fax of the adverse determination delivered to the provider and addressed to you shall be deemed legal notification to you of the adverse determination. If you elect to continue with a hospitalization, course of treatment, level of care or supplies, services, drugs or treatment after you have been notified that the MNRO has determined that it is not Medically Necessary, you (not the Plan) will be responsible for all charges for such supplies, services, drugs or treatment.

Retrospective Review

The Plan shall have the right to have the MNRO conduct a Medical Necessity review of supplies, drugs or services after they have been furnished (retrospective review). The Plan may obtain a retrospective review of any supplies, services, drugs or treatment. You and/or your provider will be notified if the MNRO
determines on retrospective review that any supplies, services, drugs or treatment are not Medically Necessary. If the MNRO determines on retrospective review that such supplies, services, drugs or treatment were not Medically Necessary, you (not the Plan) will be responsible for all charges for such supplies, services, drugs or treatment. See Appeals/External Review for more information on services deemed not medically necessary and member recourse.

The MNRO will notify you and/or your provider of its decision in writing within 5 working days of making an adverse retrospective review determination.

The Plan will not seek retrospective review of any supplies, drugs or services more than 180 days after such supplies, services, drugs or treatment were furnished.

**Standard Appeals and External Review Procedures**

When the MNRO has determined that supplies, services, drugs or treatment are not Medically Necessary, this is an “adverse determination.” You and/or your provider have the right to request an Informal Reconsideration of an adverse determination. You have the right to appeal an adverse determination on Initial Determination to the MNRO for a First Level Standard Appeal, regardless of whether you have requested an Informal Reconsideration. If you receive an adverse determination on the First Level Standard Appeal, you may appeal that decision to the MNRO for a Second Level Review. If you receive an adverse determination on the Second Level Review, you may appeal that decision to the Independent Review Organization (IRO) for a Standard External Review.

The decisions of an IRO on Standard External Reviews are BINDING on you and the Plan. This means that both you and the Plan must abide by the decision of the IRO, and that no further review (judicial or otherwise) of Medical Necessity may be sought by either party. This also means that neither you nor the Plan may sue to have a court determine the issue of Medical Necessity of the supplies, services, drugs or treatment which was the subject of the Standard External Review.

**Informal Reconsideration**

In a case involving a prospective review determination or a concurrent review determination, an MNRO shall give the provider rendering the service an opportunity to request, on behalf of the covered person, an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination. The request for Informal Reconsideration must be initiated within 10 days of the adverse determination.

The informal reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the MNRO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one working day.

**First Level Standard Appeal**

The First Level Standard Appeal must be initiated within 60 days of the adverse determination. The appeal must be initiated with the MNRO, in accordance with the written instructions accompanying the written notice of the adverse determination. If you do not appeal an adverse determination within 60 days, the determination becomes final, and is not subject to further review or appeal. The appeal may be initiated by you, a person acting on your behalf, or by your physician.

**IMPORTANT NOTE:** The request for an Informal Reconsideration does NOT stop the running of the 60 days to appeal. Whether or not you have requested or received an Informal Reconsideration, you MUST initiate your First Level Standard Appeal within 60 days of the adverse determination.
For the adverse determination to be upheld, a physician must concur in the initial denial (adverse determination). If your physician is a specialist, the concurring physician will be of the same specialty as your physician.

The MNRO will notify you and/or your physician of its decision within 30 days of their receipt of the appeal or any additional information that may be required.

The written notification will contain the following:
- The title and credentials of the physician reviewer affirming the adverse determination
- Reason for the request for appeal
- A specific explanation in laymen’s terms of the reviewers’ decisions and the medical rationale in sufficient detail for the covered person to respond further.
- If the denial is upheld, a description of the process of obtaining a second level appeal, and the written procedures regarding such.

**Standard Second Level Appeal**

If you wish to request a second level review following an adverse decision on first level standard appeal, the following process shall be followed:

The Second Level Review must be initiated within 30 days of the adverse decision on First Level Standard Appeal. The appeal must be initiated with the MNRO, in accordance with the written instructions accompanying the written notice of the adverse decision on first level appeal. If you do not appeal an adverse first level appeal decision within 30 days, the decision becomes final, and is not subject to further review or appeal.

The Second Level Review shall have a clinical peer in the same or similar specialty that would manage your condition, who must concur in any adverse decision. The clinical peer will not have participated in the initial adverse determination. Additionally, if a panel is used, the majority of the panel must be health care professionals with appropriate expertise, and must not have participated in the initial adverse determination.

If utilized, the panel shall schedule a meeting within 45 working days of receipt of your request for Second Level Review. You will be notified in writing of the date, time and place of the meeting at least 15 working days in advance of the meeting. If you cannot attend the meeting, you may ask the MNRO for a postponement of the meeting. You have the right to request that the MNRO furnish you with any information about your case that is not privileged or confidential.

At the meeting, you have the following rights:
1. To be present at the meeting, or if that is geographically impractical, you may request that the MNRO allow you to participate by conference call, video conferencing, or other similar technology.
2. To present your case to the panel.
3. To submit material in support of your case both before and at the meeting.
4. To ask questions of any representative of the MNRO.

The MNRO will notify you of the decision within 5 working days of the completed meeting date. Written notification will include:
- The title and credentials of the appropriate clinical peer affirming an adverse determination.
- A statement of the nature of the appeal and all pertinent facts.
- The rationale for the decision.
- Reference to the documentation used in making the decision.
- The instructions for requesting a written statement of the clinical rationale, including clinical review criteria used to make the determination.
- Notice of the covered person’s right to an external review, and instructions for initiating external review

**Independent Review Organization Appeal**
If you are dissatisfied with the decision of the second level review, you may file a request with the Independent Review Organization (IRO) for an external review of the second level appeal adverse determination. Your treating physician must concur in the request for External Review. The identity of the IRO, and the instructions for initiating external review will be contained in your notice of the MNRO’s decision on Second Level Review. If you do not initiate an external review within 60 days of the adverse decision on Second Level Review, that decision becomes final, and is not subject to further review or appeal.

The IRO will review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider. The IRO may consider the following in reaching a decision or making a recommendation:

- The covered person's pertinent medical records
- The treating health care professional's recommendation
- Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider
- Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations
- Any applicable clinical review criteria developed exclusively and used by MNRO that are within the appropriate standard of care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria has been reviewed and certified by the appropriate licensing board of Louisiana.

Within 30 days after receipt of the Second Level Review information, the IRO will notify you, the MNRO, and your treating physician of its decision, unless a longer period of time has been agreed to by all parties.

The decisions of an IRO on Standard External Reviews are BINDING on you and the Plan. This means that both you and the Plan must abide by the decision of the IRO, and that no further review (judicial or otherwise) of Medical Necessity may be sought by either party. This also means that neither you nor the Plan may sue to have a court determine the issue of Medical Necessity of the supplies, services, drugs or treatment which was the subject of the Standard External Review.

**ExpeditEd Appeal**

If the medical condition associated with the appeal is considered life-threatening, emergent care, and/or an inpatient continued stay review, an Expedited Appeal may be initiated. Your treating physician must consent to your request for Expedited Appeal, or may, on your behalf, initiate the Expedited Appeal.

ExpeditEd Appeals must be initiated in 60 days as standard appeals.

The expedited appeal will be evaluated by a clinical peer in the same or a similar specialty as would typically manage your care.

The MNRO will make a decision and notify you and/or your treating physician as expeditiously as your condition requires, but in no case more than 72 hours after the appeal is initiated. If the original notification is not in writing, the MNRO will provide written confirmation of its decision within 2 working days of providing the initial notification. The written notification will contain the same information as in the Standard First Level Appeal notification.

If the appeal is from a concurrent review, services for which concurrent review has been requested will be payable by the Plan (subject to the terms of the Plan other than Medical Necessity) until the provider has been notified of an adverse determination. You will not be liable for services after notification to the provider until you have been notified of the adverse determination by Medical Management or the provider.

**ExpeditEd External Appeal**

If you receive an adverse determination involving an emergency medical condition being treated in the emergency room, during hospital observation, or as a hospital inpatient, your health care provider may
request an expedited external review. This request may be submitted by phone, facsimile, or e-mail. Approval of such requests will not be unreasonably withheld.

For emergency conditions, the Medical Director or his designee will provide or transmit all necessary documents and information used in making the adverse determination to the Independent Review Organization (IRO) by telephone, facsimile, or any other available expeditious method.

Besides the information and documents provided or transmitted, the IRO may consider the following in reaching a determination or making a recommendation:

- The covered person's pertinent medical records
- The treating health care professional's recommendation
- Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider
- Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations
- Any applicable clinical review criteria developed exclusively and used by the Claim Administrator that are within the appropriate standard of care, provided such criteria were not the sole basis for the decision or recommendation, unless the criteria had been reviewed and certified by the appropriate licensing board of Louisiana

Within seventy-two (72) hours of receiving the appropriate medical information for an expedited review, the IRO shall:

- Make a decision to uphold or reverse the adverse determination
- Notify the covered person, the Claim Administrator or the Pharmacy Benefit Manager, and the covered person's health care provider of the decision. Such notice will include the principal reason or reasons for the decision.

Expedited External Reviews are BINDING on you and the Plan to the same extent as Standard External Reviews. This means that both you and the Plan must abide by the decision of the IRO, and that no further review (judicial or otherwise) of Medical Necessity may be sought by either party. This also means that neither you nor the Plan may sue to have a court determine the issue of Medical Necessity of the supplies, services, drugs or treatment which was the subject of the Expedited External Review.
APPEALS/COMPLAINTS FOR SERVICES OTHER THAN MEDICAL NECESSITY

Notice of an Appeal or Grievance

The appeal or grievance provision contained herein may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

When you have an Appeal or Complaint

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With WebTPA Member Services or Express Scripts Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

- Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form:

  1-855-346-LSU1

  WebTPA
  P.O. Box 99906
  Grapevine, TX 76099-9706
  WebMD/Envoy Payer ID #75261

  Express Scripts, Inc.
  Attn: Commercial Claims
  P.O. Box 2872
  Clinton, IA 52733-2872

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

The Plan has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit an appeal request to the Claim Administrator or the Pharmacy Benefit Manager in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Plan ID card, explanation of benefits or claim form.

There are two types of standard appeals: pre-service and post-service. A pre-service claim appeal refers to any claim for a benefit under the Plan whereby the terms of the Plan require approval of the benefit in advance of obtaining the medical care. In these cases the Claim Administrator or the Pharmacy Benefit Manager will notify you or your authorized representative within 15 days of receiving your first level appeal request.

A post-service claim appeal refers to any claim for a benefit under the Plan that is not a pre-service claim. In these cases the Claim Administrator or the Pharmacy Benefit Manager will notify you or your authorized representative within 30 days of receiving your first level appeal request. If special circumstances require
extra time to process your appeal, you will receive written notice of the extension and the reasons for it before the end of the initial 15 days. The extension will not exceed a period of 15 days from the end of the initial 15 day period. If you do not receive a response to your appeal within this time limit, you should assume that the appeal has been denied and you can begin your second level appeal.

Second level appeal requests requiring clinical review, are reviewed by an independent review organization and handled by the Claim Administrator or the Pharmacy Benefit Manager. The Claim Administrator or the Pharmacy Benefit Manager reviews second level claims appeals that do not require a clinical review. If special circumstances require extra time to process your claim, you will receive written notice of the extension and the reasons for it before the end of the initial 30 days. The extension will not exceed a period of 15 days from the end of the initial 30-day period.
**OTHER PLAN INFORMATION**

If you need additional information, please contact your Human Resources department.

**Agent for Service of Legal Process**

The agent for service of legal process is:

LSU President  
LSU Plan Administrator  
Office of General Counsel  
Louisiana State University System  
3810 West Lakeshore Drive  
Baton Rouge, LA 70808

**Amendment or Termination**

The LSU System shall have the right to terminate, suspend, withdraw, amend or modify this Plan in whole or in part at any time.

**Capitations and Headings; Singular or Plural Form**

Captions and headings used in the Plan are for convenience and reference only and should not be considered in interpreting the Plan's provisions. Singular words used in the Plan should be construed as also plural wherever applicable, and vice-versa.

**Claim Administrator**

The Plan Administrator has delegated authority to the Claim Administrator to administer benefits under the Plan. WebTPA is the Claim Administrator of the Plan and is located at:

WebTPA  
P.O. Box 99906  
Grapevine, TX 76099-9706  
WebMD/Envoy Payer ID #75261

You may also contact the Claim Administrator by calling 1-855-346-LSU1.

**Contribution and Benefits**

Payments of benefits from the Health Coverage component and the Health Expense Reimbursement Plan (your Health Reimbursement Account) are made by the LSU System from its general assets. The costs of providing benefits under the Health Coverage component are shared by you and the Employer. Your share of the cost of your coverage under the Health Coverage component will be determined by your Employer on a uniform basis.

**Cost of Administering the Plan**

The LSU System intends to pay certain administrative expenses. The administrative costs of the Plan are paid out of the applicable Plan accounts.

**Governing Law**

The Plan shall be governed by the laws of the State of Louisiana.
**Member Advocates**

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

**Misstatements, Misrepresentation, or Fraud**

If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amounts. A Participant who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation must repay all amounts the Plan paid and is liable for all collection costs including attorneys' fees and court costs.

**No Employment Rights**

Neither the adoption of the Plan, nor your status as an Employee and Participant in the Plan, shall constitute a guarantee of continued employment with the Employer. Also, you cannot sell, transfer or assign either voluntarily or involuntarily the value of your benefit under the Plan.

**Pharmacy Benefit Manager**

The Plan Administrator has delegated authority to the Pharmacy Benefit Manager to administer pharmacy benefits under the Plan. Express Scripts, Inc. is the Pharmacy Benefit Manager of the Plan and is located at:

Express Scripts, Inc.
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

You may also contact the Pharmacy Benefit Manager by calling 1-855-346-LSU1

**Plan Administration and Interpretation**

All decisions concerning the interpretation and application of the Plan and the Health Expense Reimbursement Plan shall be vested in the sole discretion and authority of the Plan Administrator. The Plan Administrator has total and complete discretionary authority to determine conclusively for all parties all questions of eligibility for coverage and benefits, the status of Participants, and the amount of benefits to which such persons are entitled. The decision of the Plan Administrator shall be final, conclusive and binding on all persons, subject to the claims procedure set forth in this summary. The Plan Administrator will exercise discretion in a nondiscriminatory manner. You can contact the Plan Administrator as follows:

A.G. Monaco, Plan Administrator
LSU System Health Plan
The Louisiana State University System
304 Thomas Boyd Hall
Baton Rouge, Louisiana 70803
225.578.4904
amonaco@lsu.edu

**Plan Changes and Termination**

The Plan Sponsor may terminate, suspend, withdraw, amend, or modify the Plan or any portion thereof at any time.
Plan Sponsor

The Plan is sponsored by:
Board of Supervisors of Louisiana State University and Agricultural and Mechanical College
3810 W. Lakeshore Drive
Baton Rouge, LA  70808

Plan Year

The financial records of the Health Coverage component and the Health Expense Reimbursement Plan are kept on a Plan Year basis.

Rights to Offset Future Payments

In the event of an erroneous payment or amount of payment to a person or entity, the Plan may reduce future payments payable to or on behalf of that person by the amount of the error. In the case of an erroneous payment or amount of payment to or on behalf of a Dependent, the Plan may reduce future payments to or on behalf of the covered Employee. The right to offset does not limit the Plan's right to recover an erroneous payment in any other manner.

Right to Recover Payments

If the Plan makes a payment for covered expenses in a total amount exceeding what is necessary at the time to satisfy the Plan's intent, the Plan may recover the excess from the person to or for whom the payments were made, insurance companies, or other persons or organizations, as applicable.

A "payment," for this purpose, includes the reasonable cash value of any benefits provided in the form of services.

Tax Effect

Neither your Employer nor the Claim Administrator make any warranty as to whether any payments or benefits you receive offered through the Plan will be treated as includable in gross income for federal or state income tax purposes.
DEFINITIONS

Assistant and/or Co-Surgeon Allowable Charges

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Co-Insurance or Deductible amounts.)

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Benefits

Any amounts paid to a Participant in the Plan as reimbursement for Covered Expenses incurred by the Participant, spouse, or Dependent during a Plan Year by him, his spouse or his Dependents.

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.

Birth Services

Ante partum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: 1) uncomplicated pregnancy and labor; and 2) spontaneous vaginal delivery.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part. The following braces are specifically excluded: Copes scoliosis braces.

Brand Name Drug

A prescription drug that has a trade name and is protected by a patent (can be produced and sold only by the company holding the patent).

Charges

The term "Charges" means the actual billed charges; except when the provider has contracted directly or indirectly with WebTPA for a different amount.

Child or Children

- A legitimate, duly acknowledged, and/or legally adopted Child of the Employee and/or the Employee’s legal spouse, married or unmarried, and without respect to student or dependency status, until the Child’s 26th birthday;
• A Child in the process of being adopted by the Employee through an agency adoption, who is living in the household of the Employee, and is or will be included as a Dependent on the Employee’s federal income tax return for the current or following tax year (if filing is required);
• A Child in the legal custody of the Employee, who lives in the household of the Employee and is or will be included as a Dependent on the Employee’s federal income tax return for the current or following tax year (if filing is required);
• A Grandchild of the Employee who is not in the legal custody of the Employee, who is dependent upon the Employee for support and whose parent is a covered Dependent. If the Employee seeking to cover a Grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

Note: If the Employee Dependent parent becomes ineligible for coverage under the Program, the Employee’s Grandchild will also be ineligible for coverage, unless the Employee has legal custody of his/her Grandchild.

**Claim Administrator**

The Claim Administrator initially determines Plan eligibility, provides access to a national network of health care providers, reviews and pays claims, administers COBRA coverage, and provides medical management and customer service.

**Clinical Services**

Clinical Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Clinical Services will not be considered to be Covered Expenses.

**COBRA Continuation Coverage**

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period. For more details please see the Section entitled “COBRA Continuation Rights Under Federal Law.”

**Co-Insurance**

The term Co-Insurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

**Contracted Reimbursement Rate or Contract Rate**

The aggregate maximum amount that a Contracted Health Care Provider has agreed to accept from all sources for provision of covered health care services under the health insurance coverage applicable to the enrollee or insured.

**Contracted Health Care Provider**

A health care provider that has entered into a contract or agreement directly with a health insurance issuer or with a health insurance issuer through a network of providers for the provision of covered health care services. First Choice Providers and In-Network Providers are Contracted Health Care Providers.

**Co-Payment**

Fixed dollar amounts an insured person is required to pay for Brand and Specialty Prescription Drugs once the Deductible is met.
Cosmetic Surgery

Any operative procedure performed primarily:
- To improve physical appearance; or
- To treat a mental or nervous disorder through a change in bodily form; or
- To change or restore bodily form without correcting or materially improving a bodily function.

Covered Services

Services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease that are either covered and payable under the terms of the Plan or required by law to be covered.

Covered Expenses

The amount of payment for Covered Services (as set forth in this document): For In-Network Medical and Pharmacy Providers, Covered Expenses are limited to the Contract Reimbursement Rate set forth in the applicable contract with the Contracted Provider. In-Network Providers are prohibited from collecting any amount in excess of the Contracted Reimbursement Rate. Covered Expenses for Out-of-Network Providers are limited to the Maximum Reimbursable Charge (MRC) for the items or services furnished, as determined by the Plan Administrator, in accordance with the section entitled “Maximum Reimbursable Charge.” Out-of-Network Providers may pursue collection from the Member of any amount in excess of the MRC. All Covered Expenses are subject to Plan Deductibles and may be payable from HRA funds, if available.

Critical Illness Direct Cash Benefit

A benefit provided for members diagnosed with any of the following illnesses: Invasive Cancer, Heart Attack; Kidney (Renal) Failure, Stroke, Organ Transplant, or Coronary Artery Bypass Surgery as each is defined in this Plan. The benefit requires payment of at least $5,000 in Covered Expenses after diagnosis that is related to one of the illnesses set forth above.

Coordination of Benefits

A provision used to establish the order in which health insurance plans pay claims when more than one plan is liable for the claims.

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 Services

Custodial Services are any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:
• Services related to watching or protecting a person;
• Services related to performing or assisting a person in performing any activities of daily living, such as:
  o Walking
  o Grooming
  o Bathing
  o Dressing
  o Getting in or out of bed
  o Toileting
  o Eating
  o Preparing foods
  o Taking medications that can be self-administered
• Services not required to be performed by trained or skilled medical or paramedical personnel.

Date Acquired

The date a Dependent of a covered Employee is acquired in the following instance and on the following dates only:

• Legal spouse – the date of marriage;
• Child or Children –
  o Natural Children – the date of birth;
  o Children in the process of being adopted:
    • Agency adoption – the date the adoption contract was executed between the Employee and the adoption agency;
    • Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee. The Program must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;
• Child who lives in the household of the covered Employee and is currently or will be included as a Dependent on the Employee’s federal income tax return – the date of the court order granting legal custody;
• Grandchild of the Employee that is not in the legal custody of the Employee, but who is dependent upon the Employee for support and whose parent is a covered Dependent:
  o The date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or
  o The date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

Deductible

The Deductible includes your Health Reimbursement Account (HRA) and your Remaining Deductible. The amount of your Deductible is based on your coverage tier and the effective date of your coverage.

Dependent

Any of the following persons, if they are not also covered as an Employee:
1. Legal spouse of Employee/Retiree.
2. A Child from date of birth up to 26 years of age;
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
**Diagnosed/Diagnosis**

A definitive and unequivocal diagnosis made by a Physician: (1) based upon the use of clinical and/or laboratory investigations as supported by the Employee's medical records; and (2) meeting any Diagnostic Requirements set forth in this Certificate for the particular Covered Critical Illness being diagnosed.

**Doctor or Physician**

The term Doctor or Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:
- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

**Durable Medical Equipment**

Items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable and where the primary purpose is not for convenience and/or patient comfort.

Such equipment includes, but is not limited to:
- Crutches
- Hospital beds
- Respirators
- Wheel chairs
- Dialysis machines

**Effective Date**

The date on which the Participant's coverage under this Plan began.

**Emergency Care**

Medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such 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:
- Placing the health or survival of the individual (or, with respect to a pregnant woman, the health or the woman or her unborn Child) in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
**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). No person appointed on a restricted appointment, or a temporary appointment, will be considered an eligible Employee. 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**

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.

**Enrollment Form**

The Enrollment Form refers to the State of Louisiana Office of Group Benefits Enrollment/Change Form (GB-01), unless otherwise specified.

**Essential Benefits**

The Affordable Care Act currently defines essential benefits as:

- Ambulatory Patient Services
- ER Services
- Hospitalization
- Maternity and newborn care
- Mental Health/ Substance Use Disorder including behavioral health treatment
- Prescription Drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care

**Expense Incurred**

An expense is incurred when the service or the supply for which it is incurred is provided.

**Experimental or Investigational**

The use of any services, tests, treatments, supplies, devices, drugs or facilities that:

- Are not approved by federal or other entities recognized by the medical profession as having special expertise in medical practice
- Are not recognized as accepted medical practice by the Plan Administrator
- Are not approved at the time charges are incurred

In determining whether a service or supply is Experimental or Investigational, opinions from any of the following maybe considered:

- The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association
- The Office of Health Technology Assessment of the U.S. Congress
- The National Institute of Health
- The Federal Food and Drug Administration
• The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS)

**External Prosthetic**

Fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- Basic limb prostheses
- Terminal devices such as hands or hooks
- Speech prostheses
- Artificial Eyes

**First Choice Provider**

A Healthcare Provider that has met certain established standards and has agreed to accept the First Choice Provider Contract Reimbursement Rate from the Plan for Covered Expenses.

**Flexible Benefit Plan**

A tax-saver benefit plan, pursuant to IRC Section 125, which allows employees to make pre-tax payroll deductions into a Flexible Spending Account for reimbursement of qualified medical and dependent care expenses.

**Free Standing Surgical Facility**

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- It has a medical staff of Physicians, Nurses and licensed anesthesiologists
- It maintains at least two operating rooms and one recovery room
- It maintains diagnostic laboratory and x-ray facilities
- It has equipment for emergency care
- It has a blood supply
- It maintains medical records
- It has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis
- It is licensed in accordance with the laws of the appropriate legally authorized agency

**Generic or Generic Drug**

A prescription drug that is a chemically equivalent copy designed from a Brand Name Drug whose patent has expired. A generic is typically less expensive and sold under a common or "generic" name for the drug.

**Genetic Testing**

A proven testing method for the identification of genetically-linked inheritable diseases.

**Geographic Area**

A zip code area, or a greater area if the Plan Administrator determines it is needed to find an appropriate cross section of accurate data.

**Group Health Plan**

A plan (including a self-insured plan) offered or contributed to, by an employer (including a self-employed person) or employee organization to provide health care to employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, and/or their families.
**Health Reimbursement Account (HRA)**

The account established by the Plan to fund a portion of the Deductible, based on the coverage tier and Plan Option selected.

**Heart Attack**

The death of a portion of the heart muscle as a result of inadequate cardiac blood supply to the relevant area.

**HIPAA**


**Home Health Agency**

A public or private agency that provides Skilled Nursing functions or activities in the covered person’s or covered Dependent’s home. It is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

**Home Healthcare Plan**

An established plan of care which is Medically Necessary, approved in writing, and reviewed every 2 months or more frequently if necessary by the attending Doctor, and which describes intermittent care and treatment for the patient’s recovery of health or physical strength.

**Home Health Care Visit**

A visit that equals four consecutive hours within a 24-hour period.

**Hospice Care Program**

The term Hospice Care Program means:
- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families
- A program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness
- A program for persons who have a Terminal Illness and for the families of those persons

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

The term Hospice Facility means an institution or part of it which:
- Primarily provides care for Terminally Ill patients
- Is accredited by the National Hospice Organization
- Meets standards established by CG
- Fulfills any licensing requirements of the state or locality in which it operates

**Hospital**

The term Hospital means:
- An institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- An institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- An institution which: (a) specializes in treatment of Mental Health and Substance Use Disorder or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

**Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he is:
- A registered bed patient in a Hospital upon the recommendation of a Physician;  
- Receiving treatment for Mental Health and Substance Use Disorder Services in a Partial Hospitalization program;  
- Receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

**HRA Rollover**

An 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, and may accumulate in a Participant’s Health Reimbursement Account throughout a Participant’s Period of Coverage.

**Illness**

Accidental bodily injury, sickness, or disease including pregnancy. Mental Illness is defined elsewhere in the Plan.

**Infertility**

The inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

**Infertility Treatment Services**

- Fertility tests and drugs;  
- Tests and exams done to prepare for or follow through with induced conception;  
- Direct attempts to cause pregnancy by any means including:  
  o Hormone therapy or drugs  
  o Artificial insemination  
  o In-vitro fertilization  
  o Embryo transfer

**Intensive Care Unit**

A section, ward or wing within the Hospital which:
- Is separated from other Hospital facilities  
- Is operated exclusively for the purpose of providing professional care and treatment for critically ill patients  
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use  
- Provides room and board; and  
- Provides constant observation and care by Registered Nurses or other specially trained Hospital personnel
**Injury**

Bodily injury:
1) Which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under the Plan is in force, and
2) Which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss

**In-Network Pharmacy**

A Pharmacy that has contracted with Express Scripts to accept an agreed-upon Contracted Reimbursement Rate for the provision of Covered Pharmacy Services.

**In-Network Medical Provider**

A Health Care Provider that has contracted with either Aetna ASA or Verity HealthNet to accept an agreed-upon Contracted Reimbursement Rate for the provision of Covered Medical Services.

**Invasive Cancer**

A disease which is manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. For the purposes of this definition, it does NOT mean the following:
1. Pre-malignant lesions, benign tumors or polyps
2. Leukoplakia
3. Hyperplasia
4. Carcinoid
5. Any tumors in the presence of any human immuno-deficiency virus (HIV)
6. Polycythemia
7. Stage 1 Hodgkin’s disease
8. Stage A prostate cancer
9. Duke’s stage A colon cancer
10. Intraductal non-invasive breast cancer
11. Stage 0 or 1 transitional cell carcinoma of urinary bladder; and
12. Any skin cancer other than malignant melanoma with a depth of 1mm or deeper or greater than Clark level 2
13. T1N0M0 (TNM Classification System) papillary carcinoma of the thyroid less than 1 cm in diameter
14. Chronic Lymphocytic Leukemia RAI stage 0
15. In-Situ Cancer

**Kidney (Renal Failure)**

End stage failure which:
1) Presents as a chronic irreversible failure of at least one of the kidneys to function; and
2) Necessitates treatment by regular renal dialysis or kidney transplant

**Low Protein Food Products**

Those 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.
**Maximum Reimbursable Charge (MRC)**

"Maximum Reimbursable Charge" means the following as applicable to services eligible under the Plan: Covered Expenses per applicable Plan provisions up to the "Maximum Reimbursable Charge" amount.

For professional services billed on a CMS 1500, successor form or other industry standard form, "MRC" is determined at the Plan Administrator's discretion based on any of the following:
- Fee(s) that are negotiated with the Provider.
- A fee schedule based on a percentage of the published rates allowed by Medicare for the same or similar service.
- A fee schedule the Plan develops and may amend from time to time.
- A percentage of the billed charges as determined by the Plan Administrator.

For facility services billed on a UB92, successor form or other industry standard form, "Maximum Reimbursable Charge" is determined at the Plan Administrator's discretion based on any of the following:
- Fee(s) that are negotiated with the Provider
- A percentage of the billed charges as determined by the Plan Administrator.

"Maximum Reimbursable Charge" is determined solely by the Plan Administrator and is developed, in the discretion of the Plan Administrator, following evaluation and validation in accordance with one or more of the following methodologies:
- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications
- As used for Medicare.
- As determined by outside medical consultants pursuant to other appropriate source or determination accepted by the Plan Administrator.

In addition to all of the above, to assist in the determination of the "Maximum Reimbursable Charge" for a service or supply that is unusual, not provided in the Geographic Area, or provided by a small number of Providers, the Plan Administrator will consider the following:
- The complexity of the service or supply.
- The degree of skill needed.
- The Provider's specialty.
- The range of services or supplies provided by a facility.
- Plan fees for similar services in other areas

**Medicaid**

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

**Medicare**

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

**Medically Necessary/Medical Necessity**

Medically Necessary Covered Services and Supplies are those determined by the Plan Medical Management Medical Director to be:
- required to diagnose or treat an illness, injury, disease or its symptoms
- in accordance with generally accepted standards of medical practice
- clinically appropriate in terms of type, frequency, extent, site and duration
- not primarily for the convenience of the patient, Physician or other health care provider
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
**Medical Services**

Covered Services of Physicians, Hospitals (in and out-patient), and for other Non-Prescription Drug services (collectively "Medical Services").

**Member or Participant**

When referring to the Plan or the HRA, means each Employee, Retiree, and Dependent who is eligible for and duly enrolled for coverage in the Plan.

**Mental Health**

Consultation, diagnosis or treatment of any mental/nervous condition as defined in the current Diagnostic and Statistical Manual of Mental Disorders, when services are provided by a:

- hospital
- physician
- licensed consulting psychologist (LCP)
- psychiatrist
- licensed psychologist (LP)
- licensed social worker
- mental health professional

The provider must be licensed or approved by the state in which the services are provided. All care must be provided by licensed, eligible providers—such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified Employees of the centers or facilities) for outpatient care.

**Multiple Surgical Reduction**

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

**Necessary Services and Supplies**

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

**Non-Contracted Provider**

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. Also known as an Out-of-Network Provider.

**Nurse**

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."
Office of Group Benefits (OGB)

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.

Orthoses and Orthotic Devices

Orthopedic appliances or apparatuses used to support, align, prevent or correct deformities, or improve function of moveable parts of the body.

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and sub-acute facilities.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

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. Also known as a Non-Contracted Provider.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the Plan because of any Remaining Deductible or Co-Insurance.

Participant or Member

When referring to the Plan or the HRA, means each Employee, Retiree, and Dependent who is eligible for and duly enrolled for coverage in the Plan.

Participant Employer

The Louisiana State University System, the House of Representatives of the State of Louisiana, the Louisiana Senate, and the Legislative Budgetary Control Council. To the extent that a Successor Employer (as defined in the section entitled "Eligibility") is participating in the Plan, such an Employer shall be a Participant Employer with respect to Employees enrolled in the Plan.

Participating Provider

The term Participating Provider means a hospital, a Physician, Healthcare Provider, Other Health Professional, Other Health Facility, or any other health care practitioner or entity that is a Contracted Health Care Provider.

Physician or Doctor

The term Physician or Doctor means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any
other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

**Plan Sponsor**

Board of Supervisors of Louisiana State University and Agricultural and Mechanical College.

**Plan Year**

The annual accounting period of the Plan, which begins on each January 1 and ends on December 31 of each year.

**Prescription Drug Expense or Cost**

Those charges incurred by the Participant for drugs purchased while covered under the Plan. Prescription drugs may also be purchased through a mail order service. In order to be covered, such drugs must be:

- necessary for the care and treatment of such Illness and prescribed by a Doctor; and
- drugs and medicines which can be obtained only by prescription and bear the legend, “Caution, Federal Law Prohibits Dispensing Without a Prescription” or are for injectable insulin, including disposable insulin needles and syringes; and
- drugs for which charges are not in excess of the Maximum Reimbursable Charge for such drugs and medicines prescribed in the area in which the prescription is filled; and
- in an amount not to exceed a 90-day supply. The physician, pharmacist, or pharmacy benefit manager may impose additional dispensing limits as they deem appropriate.

**Preventive Care**

A pattern of nursing and medical care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease, discovery and identification of people at risk of development of specific problems, counseling, and other necessary intervention to avert a health problem.

**Provider**

A Physician, Hospital, or other licensed provider of medical services or medical supplies including but not limited to an Audiologist, Physician Assistant, Advanced Practitioner Nurse, Certified Registered Nurse Anesthetist, Board Certified Social Worker, physical therapist, occupational therapist, speech therapist or licensed psychologist, acting within the scope of their license, and if required by law, under the supervision of a licensed physician.

**Provider Network**

An organization which has contracted with a panel of Participating Providers to furnish, at negotiated costs, medical services and medical supplies to applicable Participants.

**Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.
**Rehabilitation Hospital**

A facility licensed by the applicable state regulatory authority that is primarily engaged in providing rehabilitation care on an inpatient basis. Rehabilitation care consists of the combined use of medical, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

**Remaining Deductible**

The Remaining Deductible amount is your Deductible less your HRA.

**Retiree**

An individual, who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

1. Immediately received retirement benefits from an approved state or governmental agency defined benefit plan;
2. Not eligible for participation in such plan or legally opted not to participate in such plan; and either:
   a. Began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or
   b. Began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
   c. Was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
   d. Maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state Employee to receive a retirement benefit from an approved state governmental agency defined benefit plan.
3. Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.
4. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2, or 3 above.

**Sickness**

The term Sickness means a physical or mental illness, and includes attention deficit and hyperactivity disorder. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn Child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

**Skilled Nursing Facility or Extended Care Facility**

An institution or a distinct part thereof, including an intermediate nursing facility, which:
- is licensed pursuant to state and local laws;
- is operated primarily for the purpose of providing Skilled Nursing care and treatment for individuals convalescing from Injury or Illness/Sickness;
- is approved by and is a participating facility with Medicare;
- has organized facilities for medical treatment;
- provides 24-hour-a-day nursing service under the full-time supervision of a Physician or Registered Nurse;
- maintains daily clinical records on each patient;
• has available the services of a Physician under an established agreement;
• provides appropriate methods for dispensing and administering drugs and medicines;
• has transfer arrangements with one or more Hospitals; a utilization review plan in effect; and
  operational policies developed with the advice of and reviewed by a professional group including at
  least one Physician; and
• is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a
  place for alcoholics; or a place for the treatment of mental illness.

**Specialty/Injectable Drugs**

Medications used to treat chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid
arthritis.

**Splints**

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or
movable parts.

**Stroke**

1) a cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or
embolization from an extra-cranial source lasting more than 24 hours; and
2) producing measurable neurological deficit persisting for at least 30 days following the occurrence of
the Stroke. The following are not considered Strokes:
   a. Transient Ischemic Attacks (TIAs)
   b. Vertebro-Basilar Insufficiency
   c. Incidental Findings on imaging studies

**Sub-Acute Facility**

A facility that provides sub-acute care, which is generally more intensive than traditional nursing facility care
and less than acute care. It requires frequent (daily to weekly) recurrent patient assessment and review of
the clinical course and treatment plan for a limited (several days to several months) time period, until the
condition is stabilized or a predetermined treatment course is completed.

**Substance Use Disorder**

Substance Use Disorder is defined as a condition, as defined in the current Diagnostic and Statistical Manual
of Mental Disorders, resulting in the psychological or physical dependence on alcohol or other mind-altering
drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the
treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or
addiction will not be considered to be charges made for treatment of Substance Use Disorder. The treatment
plan must be recommended by a Physician to be eligible for coverage. All care must be provided by
Providers - such as Hospitals or Residential Treatment Programs for inpatient care, and non-residential
programs (including Hospital Centers, Treatment Facilities, Physicians and qualified employees of the centers
or facilities) for outpatient care.

**Substance Use Disorder Detoxification Services**

Detoxification and related medical ancillary services are provided when required for the diagnosis and
treatment of addiction to alcohol and/or drugs. The Plan’s medical management will decide, based on the
Medical Necessity of each situation, whether such services are appropriate in an inpatient or outpatient
setting.
**Successor Employer**

An OGB-Eligible employer that:

1. Employs a former full-time Employee of Louisiana State University System; a former full time Employee, member, or officer of the House of Representatives of the State of Louisiana or of the Louisiana Senate, or a former full-time Employee of the Legislative Budgetary Control council who:
   a. Was participating in the Plan at the time of such former employment ceased;
   b. Transfers and/or assumes full-time employment with an Office of Group Benefits (OGB) participating employer other than the Louisiana State University System, the House of Representatives of the state of Louisiana, the Louisiana State Senate, or the Legislative Budgetary Control Council;
   c. Elects to continue to participate in the plan in accordance with OGB rules governing inter-agency 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 System, 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 State Senate, and the Legislative Budgetary Control Council, in favor of the Louisiana State University System.

**Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

**Transfer Form**

The Transfer Form refers to the State of Louisiana Office of Group Benefits Enrollment/Change Form (GB-01), unless otherwise specified.

**Transient Ischemic Attack (TIA)**

A neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

**Transplants**

Services, supplies, drugs, organ procurement and/or acquisition, and related aftercare are listed as shown below for the following human organ and bone marrow transplant which are determined to be Medically Necessary, and which are not investigational or experimental in nature. An investigational or experimental procedure is one in which the medical use of a service or supply is still under study and the service or supply is not yet recognized throughout the Provider’s profession in the U.S. as safe and effective for the diagnosis and treatment of the illness or injury. This includes but is not limited to all phases of clinical trials, all treatment protocols based on or similar to those used in clinical trials; drugs approved by the FDA under its Treatment Investigational New Drug regulation.

- allogeneic and syngeneic bone marrow transplants
- autologous bone marrow transplants
- heart or heart/lung
- liver (cadaver or living)
- lung (single or double)
• pancreas for a diabetic with end stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired
• kidney (cadaver or living)
• cornea
• small bowel

Bone marrow transplants include stem cells from bone marrow, peripheral blood, and umbilical cord blood sources. In addition, the transplant program provides living donor coverage for kidney, liver, and bone marrow transplants, testing of potential donors, donor evaluation and workup, and hospital and professional services related to organ procurement. In the case of living donors, the Plan will coordinate benefits with the donor’s health coverage (see section entitled, "Coordination of Benefits").

**Urgent Care Center**

A facility operated to provide health care services in emergencies or after hours. It is not part of a Hospital.
Important Notices

Women’s Health & Cancer Rights Act of 1998 103
Certificate of Creditable Rx Coverage 104
Notice of Availability of HIPAA Privacy Notice 108
Premium Assistance under Medicare and CHIP 116

Remember: Keep these Notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the Certificate of Creditable Rx Coverage 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).
Women’s Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the deductibles and coinsurance applicable to the employer’s Plan apply.
Certificate of Creditable Rx Coverage

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. LSU First has determined that the prescription drug coverage offered by the LSU First health plan, 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 through 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 not be affected. If you do decide to join a Medicare drug plan and drop your current LSU First coverage, be aware that you and your dependents may not be able to get this coverage back. If you join a Medigap Plan, 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:

A.G. Monaco, Plan Administrator, 225-578-4904

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.

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).

1/1/2014

Name of Entity/Sender:

LSU First
A.G. Monaco, Plan Administrator
304 Thomas Boyd Hall
Baton Rouge, LA 70803
225-578-4904
Effective September 23, 2013

HIPAA Privacy Practices Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, contact LSU First, A.G. Monaco, Plan Administrator, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, 225-578-4904.

Who Will Follow This Notice

This notice describes the medical information practices of the LSU System group health plan (the "Plan") and that of any third party that assists in the administration of Plan claims under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and describes how the Plan will use or disclosure your Protected Health Information to carry out treatment, payment, or healthcare operations, or for any other purpose permitted or required by law.

We are required by law to maintain the privacy of your protected health information, to provide you with a notice of our legal duties and privacy practices with respect to your protected health information, and to follow the terms of the notice that is currently in effect. We are also required to notify affected individuals in the case of a breach of unsecured protected health information.

HIPAA only protects certain medical information known as “protected health information.” Generally, protected health information is information created or received by a health care provider, a health care clearing house, a health plan, or your employer on behalf of your health plan, from which it is possible to identify your and which relates to: (1) your past, present, or future physical or mental health condition; (2) the provision of health care to you; or (3) the past, present, or future payment of health care claims on your behalf. Note: The individually identifiable health information of a person who has been deceased for more than 50 years is not protected health information under the Privacy Rule.

Our Pledge Regarding Protected Health Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor’s use and disclosure of your medical information created in the doctor's office or clinic.
This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

**How We May Use and Disclose Your Protected Health Information**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment (as described in applicable regulations).** We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

**For Payment (as described in applicable regulations).** We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations (as described in applicable regulations).** We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage, submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For
example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

**To Health Plan Sponsor.** For plan administration purposes, your protected health information may be disclosed to specifically designated employees of your employer. Those employees will only use or disclose that protected health information necessary to perform plan administration functions or as otherwise required or permitted by HIPAA. Your employer may not use protected health information for employment purposes without your express authorization. Information may be disclosed to another health plan maintained by LSU First for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to LSU First personnel solely for purposes of administering benefits under the Plan.

**To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on behalf of the Plan or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate such as a third-party administrator to process your claims for Plan benefits.

**Prohibition on Use or Disclosure of Genetic Information.** The plan (other than the long-term care plan, if applicable,) is prohibited from using or disclosing your genetic information for underwriting purposes.

**Treatment Alternatives or Health-Related Benefits and Services.** We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services.

**Special Situations**

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose medical information about you for public health activities.

These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths,
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
• to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
• to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

• in response to a court order, subpoena, warrant, summons or similar process;
• to identify or locate a suspect, fugitive, material witness, or missing person;
• about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement;
• about a death we believe may be the result of criminal conduct;
• about criminal conduct at the hospital, and
• in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary:

(a) for the institution to provide you with health care;
(b) to protect your health and safety or the health and safety of others; or
(c) for the safety and security of the correctional institution.

**Uses and Disclosures for Which Your Written Authorization is Required.** We may use or disclose your personal health information only with your written authorization to your spouse, another family member such as a parent for an adult child, or a close personal friend designated by you to receive your protected health information, including an individual involved in your care prior to your death, unless you object.
Your Rights Regarding Your Protected Health Information

You have the following rights regarding medical information we maintain about you:

**Right to Restrict Disclosure of Certain Protected Health Information.** You have the right to request a restriction on disclosures of your protected health information if: (1) the disclosure is to a health plan for purposes of carrying out payment or health care operations (but not treatment); AND (2) the protected health information relates to a health care item or service for which the provider has already been paid by you in full.

**Right to Accounting of Electronic Health Records.** If the Plan maintains an electronic health record about you, you have the right to (1) obtain a copy of the information in electronic format and (2) tell the Plan to send the copy to a third party. We may charge you a reasonable fee for our labor costs for sending the electronic copy of your health information. The Plan requires you to make the request for electronic copies of your PHI in writing, and the Plan may charge you a reasonable fee for labor costs for sending the electronic copy of your health information. To request an account of electronic health records, you must make the request in writing to LSU First, A. G. Monaco, Plan Administrator, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, 225-578-4904. The Plan will send the information to a third party at your request only if you provide complete information including the name and address of the third party.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to LSU First. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to LSU First. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to LSU First, A.G. Monaco, Plan Administrator, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, 225-578-4904. Your request
must state a time period which may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to LSU First, A.G. Monaco, Plan Administrator, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, 225-578-4904. In your request, you must tell us:

(a) what information you want to limit;
(b) whether you want to limit our use, disclosure or both; and
(c) to whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to LSU First, A.G. Monaco, Plan Administrator, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, 225-578-4904. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to be Notified of a Breach.** You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of your unsecured protected health information. Business Associates include the Business Associates themselves and their subcontractors.

**A Note About Personal Representatives.** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child. The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact LSU First, A.G. Monaco, Plan Administrator, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, 225-578-4904.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan website. The notice will contain on the first page, in the top left-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated you may file a complaint with the Plan. To file a complaint with the Plan, contact LSU First, A.G. Monaco, Plan Administrator, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, 225-578-4904. All complaints must be submitted in writing. In addition to filing a complaint with the Plan you may file a complaint with the Secretary of the Department of Health and Human Services.

For complaints involving covered entities located in Arkansas, Louisiana, New Mexico, Oklahoma, or Texas:
Region VI, Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Voice Phone (214) 767-4056. FAX (214) 767-0432. TDD (214) 767-8940.

For all complaints filed by e-mail send to: OCRComplaint@hhs.gov.

You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.
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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in the following State, you may be eligible for assistance paying your employer health plan premiums. Contact your State for further information on eligibility.

Louisiana Medicaid

Website:  http://www.lahipp.dhh.louisiana.gov

Phone: 1-888-695-2447

To see if any more States have a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565