LSU First
Louisiana State University System Health Plan

Summary Plan Document
Effective January 1, 2017– December 31, 2017

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Claim Administrator

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Pharmacy Benefit Manager
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</table>
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 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.

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

**LSU FIRST HIGHLIGHTS**

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, online Employee Assistance Program (EAP), and Wellness programs. Citizens Rx provides all prescription drug retail services. PraxisRx provides all home delivery and specialty drugs services. 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 your Human Resources Department. You may also contact the U.S. Department of Health and Human Services at 1-877-696-6775 or [www.hhs.gov](http://www.hhs.gov). Please see “Important Notices” section 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.

Section 1557 of the Affordable Care Act

LSU complies with Section 1557 of the Affordable Care Act. Consistent with the Affordable Care Act, sex-specific health care is not denied or limited on the ground that the person seeking such services identifies as belonging to another.

- If the service is Medically Necessary and LSU does not categorically exclude coverage for all health services related to gender transition.

LSU does not limit sex-specific recommended preventative services based on sex assigned at birth, gender identity or recorded gender.

- If a Physician determines that a preventative service is medically appropriate and you meet the criteria for this recommendation and coverage requirements.

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.

SUMMARY OF BENEFITS AND COVERAGE

Successors

This Summary Plan Document ("SPD") is the primary document that sets forth the terms of the Louisiana State University System Health Plan, also known as "LSU First" or "the Plan." 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"

Timely Premium Remittance is Required by Successor Agencies

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

In the event that the agency does remit premiums within 15 business days of the due date all covered employees will be terminated the 1st of the following month. LSU First will notify the agency and it is the agencies responsibility to notify the employee of their options.

Coverage in LSU First is only allowable upon the first transfer of employment to a Successor Agency. Upon transfer to another, agency, even one which is a Successor Agency, coverage in LSU First is no longer available.
Eligible members of the legislator should reference Act 366 of 2007 and refer to their Human Resource department for applicable premiums.

Participation in the Plan in Successor Agencies

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

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

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

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.

Notwithstanding any other language in this SPD to the contrary, only Employees who (i) transferred to a Successor Agency prior to January 1, 2017 and (ii) were eligible to and did elect to continue LSU First coverage at that time may continue membership in LSU First. Any Employee of LSU or any other participating agency who transfers to another state agency on or after January 1, 2017 will NOT be eligible to continue participation in LSU First under the Successor Employer or Successor Agencies provisions.
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. Coinsurance for Covered Medical Services (up to the Out-of-Pocket Maximum which includes HRA, Deductibles, Medical Expense Coinsurance and Prescription Drug Copayments)
3. Co-Payments for Brand Name and Specialty Prescription Drugs (up to the Out-of-Pocket Maximum)

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.

<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 or Generic Drugs, 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:

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Annual Total HRA Maximum</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.
Rollover Rules:

- Rollover HRA applies to the Remaining Deductible.
- Previous year’s claims paid in the current year cannot use the current year’s HRA funds.
- First Choice providers and Generic Drug claims can only use the current year’s HRA funds. Rollover HRA funds are not eligible for these types of claims.
- Current year claims will be paid from any available current year’s HRA funds before they pull from any rollover HRA funds available.

IMPORTANT NOTE: The HRA and Flexible Spending Accounts

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

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

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

Overview of the Remaining Deductible

Once your HRA is exhausted, you are responsible for 100% of the Remaining Deductible. **Covered Medical Expenses at First Choice Providers 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</strong></td>
<td></td>
</tr>
<tr>
<td><strong>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><strong>Total Deductible</strong></td>
<td>$1,500</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><strong>Total Deductible</strong></td>
<td>$2,250</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>
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</tr>
<tr>
<td><strong>Total Deductible</strong></td>
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</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><strong>Total Deductible</strong></td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>LSU First</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Option 2</strong></td>
<td></td>
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<tr>
<td><strong>Employee Only</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
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</tr>
<tr>
<td>Remaining Deductible</td>
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</tr>
<tr>
<td><strong>Total Deductible</strong></td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td></td>
</tr>
<tr>
<td>HRA</td>
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<tr>
<td>Remaining Deductible</td>
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<tr>
<td><strong>Total Deductible</strong></td>
<td>$3,750</td>
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<tr>
<td><strong>Employee + Child(ren)</strong></td>
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</tr>
<tr>
<td>HRA</td>
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</tr>
<tr>
<td>Remaining Deductible</td>
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</tr>
<tr>
<td><strong>Total Deductible</strong></td>
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</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><strong>Total Deductible</strong></td>
<td>$5,000</td>
</tr>
</tbody>
</table>
**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>Employee + Child(ren)</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1st</td>
<td>$1,000.00</td>
<td>$500.00</td>
<td>$1,500.00</td>
<td>$750.00</td>
</tr>
<tr>
<td>February 1st</td>
<td>$917.00</td>
<td>$458.00</td>
<td>$1,375.00</td>
<td>$688.00</td>
</tr>
<tr>
<td>March 1st</td>
<td>$833.00</td>
<td>$417.00</td>
<td>$1,250.00</td>
<td>$625.00</td>
</tr>
<tr>
<td>April 1st</td>
<td>$750.00</td>
<td>$375.00</td>
<td>$1,125.00</td>
<td>$563.00</td>
</tr>
<tr>
<td>May 1st</td>
<td>$667.00</td>
<td>$333.00</td>
<td>$1,000.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>June 1st</td>
<td>$583.00</td>
<td>$292.00</td>
<td>$875.00</td>
<td>$438.00</td>
</tr>
<tr>
<td>July 1st</td>
<td>$500.00</td>
<td>$250.00</td>
<td>$750.00</td>
<td>$375.00</td>
</tr>
<tr>
<td>August 1st</td>
<td>$417.00</td>
<td>$208.00</td>
<td>$625.00</td>
<td>$313.00</td>
</tr>
<tr>
<td>September 1st</td>
<td>$333.00</td>
<td>$167.00</td>
<td>$500.00</td>
<td>$250.00</td>
</tr>
<tr>
<td>October 1st</td>
<td>$250.00</td>
<td>$125.00</td>
<td>$375.00</td>
<td>$188.00</td>
</tr>
<tr>
<td>November 1st</td>
<td>$167.00</td>
<td>$83.00</td>
<td>$250.00</td>
<td>$125.00</td>
</tr>
<tr>
<td>December 1st</td>
<td>$83.00</td>
<td>$42.00</td>
<td>$125.00</td>
<td>$63.00</td>
</tr>
</tbody>
</table>

**New Hire Table for Option 2**

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Employee Only</th>
<th>Employee + Spouse</th>
<th>Employee + Child(ren)</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1st</td>
<td>$1,000.00</td>
<td>$1,500.00</td>
<td>$2,250.00</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>February 1st</td>
<td>$917.00</td>
<td>$1,375.00</td>
<td>$2,063.00</td>
<td>$1,833.00</td>
</tr>
<tr>
<td>March 1st</td>
<td>$833.00</td>
<td>$1,250.00</td>
<td>$1,875.00</td>
<td>$1,500.00</td>
</tr>
<tr>
<td>April 1st</td>
<td>$750.00</td>
<td>$1,125.00</td>
<td>$1,688.00</td>
<td>$1,334.00</td>
</tr>
<tr>
<td>May 1st</td>
<td>$667.00</td>
<td>$1,000.00</td>
<td>$1,500.00</td>
<td>$1,250.00</td>
</tr>
<tr>
<td>June 1st</td>
<td>$583.00</td>
<td>$875.00</td>
<td>$1,313.00</td>
<td>$1,167.00</td>
</tr>
<tr>
<td>July 1st</td>
<td>$500.00</td>
<td>$750.00</td>
<td>$1,125.00</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>August 1st</td>
<td>$417.00</td>
<td>$625.00</td>
<td>$938.00</td>
<td>$833.00</td>
</tr>
<tr>
<td>September 1st</td>
<td>$333.00</td>
<td>$500.00</td>
<td>$750.00</td>
<td>$667.00</td>
</tr>
<tr>
<td>October 1st</td>
<td>$250.00</td>
<td>$375.00</td>
<td>$563.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>November 1st</td>
<td>$167.00</td>
<td>$250.00</td>
<td>$333.00</td>
<td>$250.00</td>
</tr>
<tr>
<td>December 1st</td>
<td>$83.00</td>
<td>$125.00</td>
<td>$188.00</td>
<td>$167.00</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”), 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.

v06302017
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. **Coinsurance for Covered Medical Expenses**

After you have satisfied your Deductible, you enter the Coinsurance 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 Coinsurance 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 Coinsurance. Brand and Specialty Drugs are subject to a Co-Payment, which applies to the Out-of-Pocket Maximum. Please see “Brand Name and Specialty Prescription Drug Co-Payments”.

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**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 for First Choice Providers and Generic Drugs.**

**Medical Services In-Network Coinsurance**

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 Coinsurance**

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

- 40% 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 Coinsurance**

To protect you, LSU First has established the maximum amount you will pay in the Coinsurance component. Your percentage of Coinsurance 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 HRA, Your Remaining Deductible, Covered Medical Expenses, Covered Prescription Drug Expenses, as well as the Covered Medical and Prescription Expenses of your Dependents, contribute towards the Out-of-Pocket Maximum.
### Medical Expense Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th></th>
<th>First Choice Provider</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
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<td>(Aetna Signature</td>
<td>(A non-contracted</td>
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<td></td>
<td></td>
<td>Administrators PPO</td>
<td>Provider)</td>
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<tr>
<td></td>
<td></td>
<td>and Verity</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance You Pay</strong></td>
<td>$0</td>
<td>10% of Covered</td>
<td>40% of MRC(^2) for</td>
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<tr>
<td></td>
<td></td>
<td>Expenses plus any</td>
<td>Covered Expenses plus</td>
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<td>amount above the</td>
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<td>MRC(^2)</td>
<td>MRC(^2)</td>
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<tr>
<td><strong>LSU First Option 1</strong></td>
<td></td>
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<tr>
<td>**Out-of-Pocket</td>
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<tr>
<td><strong>Maximum</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Employee Only</strong></td>
<td>Not Applicable(^1)</td>
<td>$4,500</td>
<td>$7,500(^3)</td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td>Not Applicable(^1)</td>
<td>$6,750</td>
<td>$11,250(^3)</td>
</tr>
<tr>
<td><strong>Employee + Child(ren)</strong></td>
<td>Not Applicable(^1)</td>
<td>$6,750</td>
<td>$11,250(^3)</td>
</tr>
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<td><strong>Family</strong></td>
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<td>$15,000(^3)</td>
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<td><strong>LSU First Option 2</strong></td>
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<tr>
<td>**Out-of-Pocket</td>
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<tr>
<td><strong>Maximum</strong></td>
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</tr>
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<tr>
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<td>$12,750(^3)</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>Not Applicable(^1)</td>
<td>$11,000</td>
<td>$17,000(^3)</td>
</tr>
</tbody>
</table>

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

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

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

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

\(^3\) 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 $150 for each 30 days’ supply of Specialty prescription drugs filled. Drugs that are classified as generic specialty medications are subject to the same deductible and copay rules as brand specialty medications. Co-Payments are included in the annual Medical Plan’s Out-of-Pocket Maximum and continue for the duration of the Plan Year or until your Out-of-Pocket Maximum is reached. 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 request the Brand-Name Drug, the Brand-Name Drug will not be covered. If an equivalent Generic Drug is available and your physician requests that the pharmacy not substitute the Generic for the prescribed Brand-Name Drug, the Brand-Name Drug will not be covered. If your physician establishes medical necessity with Citizens Rx to warrant the brand, the Brand-Name Drug will be covered according to the terms of the Plan.

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 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. Any amount that the Out-of-Network Pharmacy charges you in excess of the Plan allowable amount will not apply to your Deductible or Out-of-Pocket Maximum.

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 Coinsurance 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”).

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

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

To Locate a Provider
To determine if a Provider is in any of the networks above, log onto www.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. If you receive services from a Non-Contracted Provider, you are responsible for any amount the provider charges in excess of the Plan allowed amount. There is no limit to what an Out-of-Network provider can charge you, and any amount you pay in excess of the Plan allowed amount does not apply to your deductible or Out-of-Pocket Maximum.

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 to satisfy. For a complete list of qualifying Preventive Care Services, see the section entitled, “Preventive Care/Wellness”. 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.

Accessing LSU First Plan Information and Your Personal Account Information Online
First, go to 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, you can click on “My Accounts” to access both webtpa.com and www.citizensrx.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 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.citizensrx.com](http://www.citizensrx.com), you can:

- Review your claims history
- Locate Citizens Rx network pharmacies
- Go to [www.lsufirst.org](http://www.lsufirst.org) and click on “My Accounts”
- Click on [www.citizensrx.com](http://www.citizensrx.com)
- Select “Member” located on the upper right corner of the page.
- Follow steps to create a unique 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 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 order to be eligible for the LSU First, your employing agency must, in addition to the requirements listed above, comply with all HIPAA Policies and procedures set forth by the Plan Administrator.

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

An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). For these purposes, a "look back measurement period" is defined as the period established by the Employer of at least 3 but not more than 12 consecutive months for purposes of determining an employee's initial or ongoing eligibility for coverage. The initial look back measurement period and the standard look back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look back measurement period (including any administrative period established by the Employer which may follow those look back periods).

Re-Enrollment
1. An Employee, whose employment terminated while covered and is re-employed within 30 days of the termination date, will NOT be considered a New Hire.
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.

If an Employee has no Hours of Service for a period of 13 or more consecutive weeks and then earns an Hour of Service, he or she will be treated as a New Hire upon return, and eligibility for coverage under the Plan will be determined in accordance with the rules for Determining Full-Time Status above. If the returning Employee has had less than 13 consecutive weeks without an Hour of Service, the Employee will be treated as a continuous Employee and will be eligible for coverage under the plan upon return. Coverage will be effective on the first day of the month that coincides with or follows the date the Employee resumes Hours of Service, subject to completion of enrollment requirements. The Employer may elect to apply the “Rule of Parity” to periods of less than 13 weeks without an Hour of Service. Under the Rule of Parity, an Employee may be treated as a New Hire if the period with no Hours of Service is at least four weeks and is longer than the Employee’s period of employment immediately before the period with no Hours of Service.

Determining Full-Time Status
An Employee’s status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). For these purposes, a "look back measurement period" is defined as the period established by the Employer of at least 3 but not more than 12 consecutive months for purposes of determining an employee's initial or ongoing eligibility for coverage. The initial look back measurement period and the standard look back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look back measurement period (including any administrative period established by the Employer which may follow those look back periods).

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's Employer under the following circumstances, terms, and conditions for special enrollments:

1. Loss of Other Coverage -- Special enrollment may 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: Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no
later than the first day of the first calendar month following the date the completed enrollment form is received; or

d. The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated; or

e. The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance. or

f. The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

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 (as defined in the definition of "Dependent);
2. A Child from date of birth until the last day of the month in which the Child turns 26 years old;
3. Newborn Children, provided an Enrollment/Change Form (GB-01), together with a Birth Letter from the Hospital, is submitted to your Human Resource Department within 30 days from the date of birth of the Child (please see Dependent Verification Requirements below).
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" 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
The Health Plan will make the determination for coverage of overage dependents. This determination will surround the review of the eligibility request by the Plan’s contracted medical experts

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 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 have legal custody or guardianship and who is dependent on you for support:
   Certified copy of signed legal judgment granting you legal guardianship or custody.

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 and be approved for continued coverage prior to age 26. Supporting
medical documentation is required.
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.

Upon receipt of a Medical Child Support Order, the Plan Administrator shall:

1. Promptly notify, in writing, you, each alternate recipient (Child subject of the order), and each representative for these parties of the receipt of the order. The notice shall include a copy of the order and a copy of these QMCSO procedures for determining whether the order is qualified;
2. Permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order;
3. Within a reasonable time after receiving the medical child support order, determine whether it is qualified and notify the affected parties; and
4. Ensure the alternate recipient receives copies of the SPD and any Summaries of Material Modifications (SMMs) to the Plan.

**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.
Medicare and End Stage Renal Disease (ESRD)
If you are eligible for Medicare due to end stage renal disease (ESRD) you are required to enroll in Medicare Part A and Part B.

Medicare and Disability
If you are eligible for Medicare due to disability, you are required to enroll in Medicare Part A and Part B.

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.
   Note:
   • If the Employee is retired, and the Employee or spouse qualifies for Medicare for reasons other than obtaining the age of 65, the Plan will pay secondary to Medicare for that person.
   • The Plan reserves the right to periodically audit for Medicare eligibility.
   • When a Retiree is eligible for the LSU First Retiree Health Plan the Retiree is no longer eligible for LSU First Self-funded Plan.

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 Dependents to continued coverage other than a Child of the deceased Employee (born before or after the Employee’s death) with a Qualifying Life Event.

3. Participant Employer/Dependent Responsibilities

a. It is the responsibility of the Participant Employer and surviving covered Dependent to notify their Human Resource Department within 30 days of the death of the Employee or Retiree; The Human Resource Department will notify the surviving Dependents of their right to continue coverage;

b. Application for continued coverage must be made in writing to their Human Resource Department within 30 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;

c. Coverage for the surviving spouse under this section will continue until the earliest of the following:
   i. Failure to pay the applicable premium timely;
   ii. Eligibility of the surviving spouse under a Group Health Plan other than Medicare.
   iii.

d. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:
   i. Failure to pay the applicable 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.

5. A surviving spouse must notify LSU of the Employee’s death within 30 days, and the surviving spouse must elect continuation of coverage within 60 days of the date of the election notification upon eligibility. The Plan will not be financially responsible for late notification. The Plan reserves the right to periodically audit such eligibility.

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.

**Medicare Eligibility**
- The Plan will pay secondary when a person is eligible for Medicare due to age, disability, ESRD or for any other reason. Enrollment in Medicare Part A and Part B is required.
- If an Employee or an Employee's spouse is eligible for Medicare, he or she must enroll in Medicare Part A and Part B upon eligibility.

**Termination of Coverage**
The Employer or Plan has the right to rescind coverage of the Employee and/or Dependents for cause, including, but not limited to: (i) making a fraudulent claim; or (ii) making an intentional, material misrepresentation in applying for or obtaining benefits or coverage under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action, and will allow the affected person a reasonable opportunity to be heard by the Plan Administrator or his or her designee prior to the termination becoming effective. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

**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
  - Termination of Coverage for cause, in accordance with the process set forth above.

**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 day on which the Dependent, as defined in this Plan, ceases to be an eligible Dependent of the covered Employee.
• For Grandchildren for whom the Employee has legal custody or has adopted, the date the Grandchild 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.
• Termination of Coverage for cause, in accordance with the process set forth above.
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.
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.

Dependent Effective Date of Coverage
1. Dependents of Employees -- Coverage will be effective on the date the Employee becomes eligible for Dependent Coverage provided the time limits required for enrolling Dependents are met.
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.

Annual Enrollment

Unless otherwise notified, participation in the Plan will continue each Plan Year (unless you change it). However, during Annual Enrollment, eligible Employees can elect coverage if he/she previously declined it, or change the 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 penalty 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 (USERRA)**

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

**(1)** The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

**(2)** A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

**(3)** An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**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 COVERAGE RIGHTS UNDER FEDERAL LAW (“COBRA”)

Note: The following sets forth an overview of applicable provisions of COBRA. To the extent this overview may conflict with 42 USC 300bb-1 through 300bb-8 (Title XXII of the Public Health Service Act), federal law will prevail.

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under LSU System Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is The Louisiana State University System, 304 Thomas Boyd Hall, Baton Rouge, Louisiana 70803, 225.578.4904. COBRA continuation coverage for the Plan is administered by WebTPA, P.O. Box 2383, Grapevine, Texas 76099-2383, 800-758-2525. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower Out-of-Pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).
Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation (when it occurs in a state that recognizes legal separation) of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended, ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a
spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

**Is a covered Employee or Qualified Beneficiary responsible for informing the COBRA Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the COBRA Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. death of the Employee,
3. commencement of a proceeding in bankruptcy with respect to the employer, or
4. entitlement of the employee to any part of Medicare.

**IMPORTANT:**

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child’s losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the COBRA Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.
NOTICE PROCEDURES:

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

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

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the Employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
   (a) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary’s entitlement to the disability extension is no longer disabled, whichever is earlier; or
   (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
   (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
   (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee’s termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.
Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The COBRA Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

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.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.
IF YOU HAVE QUESTIONS
If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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 WebTPA (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.
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><strong>Total Payment from Plan and Member:</strong></td>
<td><strong>Total Payment from Plan and Member:</strong></td>
<td><strong>Total Payment from Plan and Member:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>HRA payment:</strong></td>
<td><strong>HRA payment:</strong></td>
<td><strong>HRA payment:</strong></td>
</tr>
<tr>
<td></td>
<td>100% of Contract Rate until exhausted</td>
<td>100% of Contract Rate until exhausted</td>
<td>100% of Maximum Reimbursable Charge (MRC) until exhausted</td>
</tr>
<tr>
<td></td>
<td><strong>Member payment:</strong> $0</td>
<td><strong>Member payment:</strong> (see below)</td>
<td><strong>Member payment:</strong> (see below)</td>
</tr>
<tr>
<td></td>
<td>Remaining Deductible: not applicable</td>
<td>Remaining Deductible: If HRA exhausted, 100% of Contract Rate up to balance of Remaining Deductible</td>
<td>Remaining Deductible: If HRA exhausted, 100% of MRC up to balance of Remaining Deductible</td>
</tr>
<tr>
<td></td>
<td>Medical Services Coinsurance: not applicable</td>
<td>Medical Services Coinsurance: After Deductible is satisfied, 10% of Contract Rate, subject to certain exceptions:</td>
<td>Medical Services Coinsurance: After Deductible is satisfied, 40% of MRC, subject to certain exceptions:</td>
</tr>
<tr>
<td></td>
<td><strong>Plan payment for Medical Services</strong></td>
<td><strong>Plan payment for Medical Services</strong></td>
<td><strong>Plan payment for Medical Services</strong></td>
</tr>
<tr>
<td></td>
<td>100% after HRA is exhausted</td>
<td>After Deductible is satisfied, 90% of Contract Rate, subject to certain exceptions:</td>
<td>After Deductible is satisfied, 60% of MRC, subject to certain exceptions:</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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Payment from Plan and Member:</strong></td>
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<td><strong>HRA payment:</strong></td>
<td><strong>HRA payment:</strong></td>
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<tr>
<td>100% of Cost until exhausted</td>
<td>100% of Cost until exhausted</td>
<td>100% of Cost until exhausted</td>
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<tr>
<td><strong>Member payment:</strong></td>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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 $150 per fill, up to 30-days’ supply</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
</tbody>
</table>

**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 and that amount, if applicable, does not apply to the Out-of-Pocket maximum.
Continuation of Care

If, in the event of a high-risk pregnancy or past the twenty-fourth week of pregnancy or diagnosis of a life threatening illness for which death is probable, the contract with a contracted health care provider is terminated, the provisions of La. R.S. 22:1005, “Continuity of Health Care Services” may be applicable. The contracted health care provider must notify the Plan of applicable Members who have begun a course of treatment prior to the effective date of the contract termination. Thereafter, the Plan shall continue payment of the Contract Rate to the provider on the same basis that was in effect prior to the termination of the contract as follows:

- High-risk Pregnancy or post twenty-fourth week of pregnancy. Through delivery and postpartum care related to the pregnancy and delivery.
- Life threatening illness. For a period of 120 days following termination of the contract.

For more information on how to qualify please call toll-free 1-855-346-LSU1 and select the Medical Management option.
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” and “Definitions”.

Services or supplies used, prescribed, or recommended in connection with any excluded or non-covered treatment or procedure, including, without limitation, any services or supplies related to or arising out of any non-covered treatment or procedure (including any complications arising from the non-covered treatment or procedure), regardless of whether such services or supplies are Medically Necessary. Member must contact WebTPA to determine eligible benefits.

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 provided by a health care provider acting within the scope of his or her license.

Plan Year Maximum is limited to a combined total of 60 days per Plan Year for Physical and Occupational Therapies and a separate 60 days per Plan Year maximum for Speech Therapy. These maximums do not apply to Medically Necessary therapies for the treatment of autism.

Anesthesia

Blood, Blood Plasma, and Transfusions
**Breast Pumps**

Breast pumps are covered at 100% of the allowable, 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 up to the purchase price as Medically Necessary for the initiation or continuation of breastfeeding for EITHER of the following indications:

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

**Breast 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 therapy are covered
- Breast reduction when deemed Medically Necessary

*NOTE: If you choose an Out-of-Network provider, you will be responsible for charges exceeding the MRC amount.*

**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

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

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

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

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

**Dialysis** If member is eligible for dialysis coverage under Medicare, LSU First will pay secondary to Medicare, regardless of whether the member is enrolled in Medicare.

**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 (predetermination by Plan Medical Management is required for equipment exceeding $1000):

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

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

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 a First Choice or In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based physicians or Providers may not be Contracted Health Care Providers.
Family Planning Services
- Office Visits, Lab and Radiology Tests and Counseling
- Contraceptives
  - Oral contraceptives
  - Emergency contraceptives
  - Contraceptive services and devices, such as IUDs, Norplant, Depo-Provera injections
- Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)
- The following are covered at 100% of the allowable and no need to use your HRA dollars:
  - Diaphragms/Cervical Caps
  - Generic hormonal contraceptives
  - Generic emergency contraceptives
  - Implantable medications
  - Intrauterine contraceptives

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

Genetic counseling is covered if a person is undergoing approved genetic testing or if a person has an inherited disease and is a potential candidate for genetic testing.

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:
Calendar Year Maximum: Limited to 60 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 60 visits in a Calendar Year by a home healthcare professional. Additional visits may be approved based upon Medical Necessity. 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** - inpatient and outpatient. If member is eligible for hospice coverage under Medicare, LSU First will pay secondary to Medicare, regardless of whether the member is enrolled in Medicare.

**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 provided by a health care provider acting within the scope of his or her license

Plan Year Maximum is limited to a combined total of 60 days per Plan Year for Physical and Occupational Therapies and a separate 60 days per Plan Year maximum for Speech Therapy. These maximums do not apply to Medically Necessary therapies for the treatment of autism.

**Warning**
The fact that a Hospital or other facility is a First Choice or In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based physicians or Providers may not be contracted health care Providers.
**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.
Routine patient care charges for **Clinical Trials**. Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

**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**

**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 and/or grandchildren

**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 health care provider acting within the scope of his or her license.

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.

Charges for treatment in a Crisis Stabilization Unit will be payable covered provided that:

- The Mental or Nervous Disorder would otherwise require Hospital Confinement;
- The services are based on an individual treatment plan; and
- The providers are properly licensed.

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.

Speech Therapy when provided by a health care provider acting within the scope of his or her license.

- Plan Year Maximum: Limited to a separate total of 60 days per Plan Year for Speech Therapy. This maximum does not apply to Medically Necessary therapy for the treatment of autism.
- all therapies Short-term Rehabilitative Therapy, when provided in the most medically appropriate setting.

The following limitations apply to Speech Therapy Services:

- Services are not covered if they are custodial, instructional, or educational.

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
<table>
<thead>
<tr>
<th>Conditions and Services</th>
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<tr>
<td>• Child/adolescent problems of conduct or poor impulse control</td>
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<td>• Affective disorders</td>
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<td>• Eating disorders</td>
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<tr>
<td>• Acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention)</td>
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<tr>
<td>• Outpatient testing and assessment</td>
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</tbody>
</table>

Regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or non-quantitative treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.
Substance Use Disorder Treatment – Covered Person must be actively engaged in Care Coordination to be eligible for Substance Abuse benefits. Active engagement is when a Covered Person who has been identified for a Care Coordination program and has consented to enrollment and working directly with the Care Coordinator on a predefined basis. The Covered Person must enroll in a Care Coordination program as soon as contacted by an eQHealth Solutions health care coordinator. In order to remain an “active” participant, they must participate in the pre-determined regular follow up with the member. Once the Covered Person becomes unable to contact, they are no longer considered an “active” participant.

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

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. Travel expenses will be considered reasonable when consecutive care is rendered within an appropriate, non-excessive length of time. 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. 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) Pre and 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); 
*mileage is reimbursed at the IRS rate for medical transportation*, lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 50 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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:
  - Rigid and semi-rigid custom fabricated orthoses
  - Semi-rigid prefabricated and flexible orthoses
  - Rigid prefabricated orthoses
- Custom foot orthoses are covered as follows:
  - For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease)
  - When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace
  - When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect
  - For persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

**Oxygen and other gases**

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

**Prescription Drug Benefits Note:** Prior authorization requirements and stated excluded drugs are subject to change throughout the Plan Year. Affected individuals will be notified.

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 Citizens Rx.

**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 full cost of the Brand Name Drug. (This amount will not apply to satisfaction of the Deductible or available HRA dollars.)

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 Citizens Rx, the Pharmacy Benefit Manager. If the compounded medication is not FDA approved, you will not be reimbursed.

Fixed-dose combination (FDC) products contain two or more active ingredients in a single dose. FDC products available as separate single generic drugs are specifically excluded from the Prescription Drug Benefit.

If you do not have your Plan ID card with you when you fill your prescription, or if you choose to use an Out-Of-Network pharmacy, you will need to pay for your prescription up front and file a claim for reimbursement. In either case, you will be reimbursed only the amount that the Plan would have paid at an In-Network pharmacy with a Plan ID card presented.
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 home delivery services. It is important to know that not every drug is available with your Plan ID card through the pharmacy.

Prescription Home Delivery
Prescription Home Delivery encourages Members to fill their maintenance medications using PraxisRx, the Citizens RX Home Delivery Pharmacy. Home Delivery allows a 90-days’ supply to be shipped directly to the Member’s home, work location or alternate address. Orders can be managed online or over the phone directly with PraxisRx. If a Member’s maintenance medications are included in this program, Citizens Rx or PraxisRx will contact the Member directly regarding this program. Participation in the Home Delivery Program is voluntary. A Member will be able to fill maintenance medication(s) at a retail pharmacy for the duration of therapy if desired.

Prior Authorization
Some medications require pre-authorization in order to be covered by the Plan. In such cases, Citizens Rx 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 and manufacturer 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 PraxisRx
The Plan utilizes PraxisRx, Citizens Rx’s specialty pharmacy. Members will be allowed one fill at retail before being required to begin using PraxisRx 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 PraxisRx, call toll free 1.888.903.7453 (Monday-Friday 8 a.m. to 8 p.m. EST)

Split Fill Program Patients who are new to select specialty medications often are unable to tolerate this form of treatment. To reduce waste and help avoid costs of medication that will go unused, the Specialty Pharmacy program provides a partial, or “split”, fill of the member's first monthly prescription for these select medications, when dispensed by PraxisRx Specialty Pharmacy. Members have the opportunity to try these drugs to determine if they can tolerate the medication and any potential side effects before continuing therapy.

The service is currently offered for nine medications: Bosulif®, Lysodren®, Nexavar®, Sutent®, Tarceva®, Targretin®, Zelboraf®, Zolinza® and Zytiga®. When a new prescription is received for one of these select medications, PraxisRx Specialty Pharmacy will contact the member to confirm participation in the split fill program before the medication is sent. (PraxisRx Specialty Pharmacy may also reach out to the member's provider if they are unable to reach the member.) If a member does not wish to have a split fill of their medication, Prime Specialty Pharmacy will ship the full prescription amount and charge the member their full share, based on the member's pharmacy benefit plan.
For members participating in the program, the first shipment is a 16-day supply. The member is contacted again prior to the second shipment of a 14-day supply being sent. Member share (copay/copayment) amounts are prorated to align with the number of pills dispensed. If the member pursues another fill thereafter, the member will receive the full supply and pay their full share. All member share costs are determined by the member’s pharmacy benefit plan. Contact Citizen Rx for list of specific drugs this applies to.

**Prescription Drug Benefit Exclusions**
Please refer to the Exclusions section on the LSU First website, [www.lsufirst.org](http://www.lsufirst.org), for additional exclusions and limitations on the prescription drug benefit.

**Preventive Care/Wellness**; see also Family Planning Services and Women’s Preventive Health

The Plan covers certain services at 100% of the allowable whether you utilize a First Choice Provider, In-Network Provider/Facility or an Out-of-Network Provider/Facility. This means that your HRA dollars will not be used, and you will not be responsible for any Remaining Deductible, Coinsurance or Co-Payments. However, 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.

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**
  o Lead level testing, one between ages 9 to 12 months and one between 12 and 24 months
  o Vision screening conducted at time of well-Child visit
  o Hearing screening conducted at time of well-Child visit
  o Pap Smear and Routine Pelvic Exam once per Plan Year, as appropriate by age

**Well-Adult Care**

• **Routine Exams and Office Visits**
  o One visit every 3 years from age 16 to age 40 years for men
  o Four visits every 3 years from age 16 to age 40 years for women
  o One visit every 2 years from age 40 to age 50 years for men
  o Three visits every 2 years from age 40 to age 50 years for women
  o Annual visits from age 50+ years for men
  o Two visits annually from age 50+ for women
  o Well-woman visit annually in addition to the annual exam schedule above.

• **Immunizations**
  • Influenza Vaccination (flu shot) annually
  • Pneumococcal Vaccination (Pneumovaz) 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 limited to one vaccine per lifetime
  • Seasonal Vaccinations Administered “in-pharmacy” at Citizens Rx Participating Pharmacies
  • Tetanus / Diphtheria (Td) Booster once every 10 years
  • Tetanus, diphtheria, and acellular pertussis (Tdap) may substitute one dose of (Tdap) for Covered Persons age 18 years up to 65 years.

• **Screenings**
  o 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.
    Routine Eye Exam - Limit 1 exam annually payable under the Preventive Care/Wellness benefit starting at age 16. Note: if you have the voluntary vision plan all benefits for vision will pay under the voluntary plan.
  o Cholesterol screening including triglycerides, LDL, HDL, annually for men age 35 years and over and women age 45 years and older
  o Mammograms, as set forth below:
    a single baseline mammogram for women ages 35 through 39; one mammogram every 12 months for women age 40 or older.
  o Pap Smear and Routine Pelvic Exam once per Plan Year, as appropriate by age
  o Bone density test annually for osteoporosis for women age 50 years and over
  o 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;
Shingles and Seasonal Vaccinations Administered "in-pharmacy" at Citizens Rx Participating Pharmacies

Seasonal influenza and pneumonia as well as shingles vaccinations are Covered Services under the Plan. In addition, Seasonal and Shingles Vaccinations are covered under your Preventive Care Benefit and the medical portion of the Plan, subject to certain limitations (see above). Members may elect to receive seasonal vaccinations "in-pharmacy" at Citizens Rx participating pharmacies. Members will not pay anything Out-of-Pocket for Seasonal Vaccines provided the vaccinations are received at a Citizens Rx 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.

<table>
<thead>
<tr>
<th>Prosthetics, External</th>
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<tr>
<td>• External Prosthetics (includes prostheses/prosthetic appliances and devices), subject to the following:</td>
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<tr>
<td>• Available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect</td>
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<tr>
<td>• Initial purchase and fitting of External Prosthetic Appliances and devices</td>
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<tr>
<td>• Coverage is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician</td>
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<td>• Coverage for replacement is limited to the following:</td>
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<tr>
<td>• Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.</td>
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- 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.

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<th>Pulmonary Rehabilitation</th>
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<td>Radiation Therapy, including x-ray and radio isotope treatment</td>
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<tr>
<td>Reconstructive Surgery</td>
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<tr>
<td>Charges made for reconstructive surgery limited to the following:</td>
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<tr>
<td>• Reconstructive surgery following a covered mastectomy;</td>
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<tr>
<td>• Surgery to repair a defect caused by an accidental injury resulting in a functional impairment;</td>
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<tr>
<td>• 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</td>
</tr>
<tr>
<td>• Cosmetic or reconstructive surgery to repair a Dependent Child’s congenital or developmental defect.</td>
</tr>
</tbody>
</table>
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.

Routine Eye Exam - Limit 1 exam annually payable under the Preventive Care/Wellness benefit. Note: if you have the voluntary vision plan all benefits for vision will pay under the voluntary plan.

Short-term Rehabilitative Therapy (Physical Therapy, Speech Therapy, and Occupational Therapy), when provided by a health care provider acting within the scope of his or her license.

- Plan Year Maximums: Limited to a combined total of 60 days per Plan Year for Physical and Occupational therapies. Limited to a separate total of 60 days per Plan Year for Speech Therapy. These maximums do not apply to Medically Necessary therapies for the treatment of autism.

- 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:

- Calendar Year Maximum: Limited to total of 90 days per Plan Year, regardless of the Provider’s network status. Additional visits may be approved based upon Medical Necessity.

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.
### Smoking Cessation

- For Covered Persons who use tobacco products, up to two tobacco cessation attempts will be covered per Calendar Year under the Medical Plan.
- All Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization will be covered under the Prescription Drug Benefit Plan.

### Speech Therapy

- Plan Year Maximum: Limited to a total of 60 days per Plan Year for Speech Therapy. This maximum does not apply to Medically Necessary therapies for the treatment of autism.

### 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.

### Telehealth

The distribution of electronic health-related services and information.
- Payable at the First Choice Provider level.
- Available through American Well – [www.amwell.com](http://www.amwell.com)

### 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 a First Choice or In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based Physicians or Providers may not be Contracted Health Care Providers.

### Virtual colonoscopy

- Subject to the following:
  - When performed in connection with diagnostic testing only.

### Vision

**Routine Annual Eye Exam**

- Limit 1 exam annually payable under the Preventive Care/Wellness benefit starting at age 16. Note: if you have the voluntary vision plan all benefits for vision will pay under the voluntary plan. 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.

### Wigs

- Subject to the following: LIFETIME LIMIT: 2 WIGS
  - Covered only when needed for hair loss due to cancer or alopecia areata.
**Women’s Preventive Health**; see also Preventive Care/Wellness

The Plan covers certain Women’s Preventive Health Services at 100% of the allowable whether you utilize a First Choice Provider, In-Network Provider/Facility, or an Out-of-Network Provider/Facility with no Remaining Deductible to satisfy and no need to use your HRA. However, 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.

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**Employee Assistance Program (EAP)**

With your Employee Assistance Program (EAP), now you can use myStrength to help enhance your emotional well-being.

It’s a new kind of online wellness portal. You can use it to support your mind, body and spirit. Best of all, it’s a free part of your program.

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety or substance abuse. Once you get set up with myStrength, you’ll log on to a home page created just for you. With the myStrength application, you can get inspired on the go by getting custom inspiration based on your mood, track your mood over time, upload your own inspiring photos and videos and opt to receive check-in reminders.

**myStrength is:**
- Clinically proven
- Free and available 24/7
- Easy to use
- Confidential

**Easy sign up:** Please visit the following website and utilize the login information below:

- [www.mylifevalues.com](http://www.mylifevalues.com)
  - Username: peaceofmind
  - Password: solutions
**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 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.
COST MANAGEMENT SERVICES

Cost Management Services Phone Number

eQHealth - 855-346-LSU1

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after a Medical Emergency.

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the Out-of-Pocket maximum.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
   a. Inpatient Hospital Admissions (including Psychiatric)
   b. Long term Acute Care
   c. Skilled Nursing Facility
   d. Inpatient Rehabilitation
   e. Home Health
   f. Pet Scans
   g. Physical Therapy (including chiropractor-billed Physical Therapy)
   h. Occupational Therapy
   i. Speech Therapy
   j. Cardiac Rehabilitation
   k. Durable Medical Equipment with purchase price over $1000
   l. ABA Therapy- Applied Behavioral Analysis Therapy
   m. Genetic Testing
   n. CT Scans
   o. MRI/MRA
   p. SPECT Scans
   q. Outpatient pain rehabilitation/pain control programs
   r. Residential Treatment Centers
   s. Mental Health (inpatient and outpatient)
   t. Methadone treatment – limited to 1 year
   u. Substance Abuse (inpatient and outpatient)
   v. Hip/Knee Replacement (Arthroplasty)Cosmetic Surgery
Services or supplies used, prescribed, or recommended in connection with any excluded or non-covered treatment or procedure, including, without limitation, any services or supplies related to or arising out of any non-covered treatment or procedure (including any complications arising from the non-covered treatment or procedure), regardless of whether such services or supplies are Medically Necessary. Member must contact WebTPA to determine eligible benefits.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here’s how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis, or receives the other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.
The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least **48 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within **48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the service may not be covered.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

**SECOND AND/OR THIRD OPINION PROGRAM**

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.
While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

- Appendectomy
- Hernia surgery
- Spinal surgery
- Cataract surgery
- Hysterectomy
- Surgery to knee, shoulder, elbow or toe
- Cholecystectomy (gall bladder removal)
- Mastectomy surgery
- Tonsillectomy and adenoidectomy
- Deviated septum (nose surgery)
- Prostate surgery
- Tympanotomy (inner ear)
- Hemorrhoidectomy
- Salpingo-oophorectomy (removal of tubes/ovaries)
- Varicose vein ligation

**PREADMISSION TESTING SERVICE**

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

1. **performed on an outpatient basis within seven days before a Hospital confinement;**
2. **related to the condition which causes the confinement; and**
3. **performed in place of tests while Hospital confined.**

**CASE MANAGEMENT**

**Case Management.** The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan
Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Claims Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Claim Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

**Note:** Case Management is a voluntary service except where required by the Summary Plan Document. Excluding required participation, there are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.
BENEFIT LIMITS AND EXCLUSIONS UNDER THE PLAN

Maximum Reimbursable Charge (MRC)

The Plan pays 60% 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.
- 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.
  - Professional services performed by the Covered Person, a person who ordinarily resides in the Covered Person's home, or is related to the Covered Person as a spouse, parent, child, brother, sister, whether the relationship is by blood or exists in law. Exclusion is based on the Covered Person's relationship to the provider, not the relationship of the Dependent to the provider.
- 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
• Covered expenses not payable because the applicable Deductible and/or Out-of-Pocket Maximum limit has not been met
• Expenses eligible for payment under any other plan, including Medicare
• Sales tax (applicable to Medical Plan only, not to Prescription Drug Benefits)
• 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
• Dry Needling
• 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. Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes or for the following:
  o Reconstructive surgery following a covered mastectomy
  o Surgery to repair a defect caused by an accidental injury resulting in a functional impairment
  o Reconstructive surgery related to or following surgery that was needed due to an injury, sickness, or other disease of that part of the body
  o 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, except as required by federal law.
• Care and treatment that is either experimental/investigational or not Medically Necessary. Care and treatment that is either experimental/investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a qualified individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the "Covered Services under the Plan" section.
• 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
• Immunizations that are required when traveling outside of the United States, even if work related
• Travel vaccinations
• Expenses for precautionary tests solely rendered to determine if a Covered Person contracted a disease while traveling outside of the United States
• Travel and/or lodging expenses of a physician or a patient, unless otherwise deemed eligible by the Plan Administrator or his designee’s approval, or as specified as covered 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, allergic 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 and/or grandchildren
• 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. Screening and counseling for obesity will be covered to the extent required under Preventive Care.
• 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 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, unless there is evidence of an underlying medical condition
  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:
  o 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
o 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:
  o Services of a chiropractor which are not within his scope of practice, as defined by state law
  o Charges for care not provided in an office setting
  o Vitamin therapy

- External Prosthetic Appliances and Devices excludes the following:
  o External and internal power enhancements or power controls for prosthetic limbs and terminal devices
  o Myoelectric prostheses peripheral nerve stimulators

- 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

- Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

- Respite care - the provision of short-term accommodation in a facility outside the home. This provides temporary relief to those who are caring for family members, who might otherwise require permanent placement in a facility outside the home.

- Impotence. Care, treatment, services and supplies in connection with treatment for impotence, unless the treatment is related to prostate cancer.

- Acupuncture.

- Massage therapy.

- Methadone treatment as maintenance (treatment over one year), L.A.A.M. (1-Alpha- Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction.

- Physician self-diagnosis (treatment of oneself) or self-prescribing.

- Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person’s home or is related to the Covered Person as a Spouse, parent, child, brother, sister, aunt or uncle, whether the relationship is by blood or exists in law or as determined by Plan Administrator.

- Membership and/or concierge fees that allow Covered Persons access to Physicians for Covered Services.

The following are specifically excluded from the Prescription Drug Benefit (see also “Covered Services under the Plan”):

- Injectable medications administered by a health care Provider (except for insulin and Depo Provera).

- Immunizations, vaccines, allergy agents for injection except for shingles vaccines (for those 60 and older), pneumonia vaccines (for those 65 and older) and influenza vaccines

- Drugs used for PrEP or antiretroviral pre-exposure prophylaxis treatment

  - Blood and blood plasma
  - Hearing aids (hearing aids may be covered as a medical item)
  - Non-legend nutritional supplements, except as required for the treatment of PKU (phenylketonuria)
  - 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
  - Products not approved for use in the United States, experimental therapy, or products purchased outside the United States, unless in an emergency situation
  - Prescription drugs for anyone other than the recipient of the prescription
• Prescriptions exceeding a reasonable quantity as determined by your Physician in consultation with Citizens Rx, the pharmacy benefits administrator
• Medical devices or equipment

• Tobacco cessation Care and treatment for tobacco cessation programs shall be covered to the extent required under Preventive Care, including smoking deterrent products. Tobacco cessation care and treatment is otherwise excluded unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.
• Weight loss medications, except as approved through Citizens Rx’s Prior Authorization Program
• Anti-wrinkle medications
• Hair growth and hair removal treatments
• De-pigmentation products used for skin conditions requiring a bleaching agent
• Non-legend medications and OTC equivalents, Non-prescription or over the counter medications except for OTC drugs that are prescribed by a Physician as required for Standard Preventive Care.
• Prescription medications with equivalent over the counter (OTC) formulations (e.g., proton pump inhibitors and seasonal allergy/antihistamine medications)
• Durable Medical Equipment, except for:
  o Respiratory Therapy Supplies (e.g. Aerochamber, Spacers, Nebulizers)
  o Non insulin syringes
• Diagnostic testing and imaging supplies (e.g. Tubersol used for TB skin test, Radiopaque dye for outpatient testing)
• Homeopathic Drugs (all dosage forms including injectable)
• 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 Citizens Rx, the pharmacy benefits manager.
• Prescriptions whereby the Physician is prescribing medication(s) for themselves or their family members are not covered. (Family is defined as those related by blood, marriage or residing in the same residence as the prescriber.)
• Relative giving services. Prescription services performed by a person who ordinarily resides in the Covered Person’s home or is related to the Covered Person as a Spouse, parent, child, brother, sister, aunt or uncle, whether the relationship is by blood or exists in law or as determined by Plan Administrator.
• Methadone treatment as maintenance (treatment over one year), L.A.A.M. (1-Alpha- Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.

Treatment, services, and/or supplies excluded under the Plan may qualify for recommendation and approval for coverage as Alternative Treatment.
FILING CLAIMS FOR 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 Coinsurance 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 90 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.

It is the responsibility of the patient to ensure that the provider has the necessary insurance coverage information in order to file a claim. If the patient is filing a manual claim on behalf of an out-of-network provider, the patient must include with the manual claim form a copy of a detailed invoice and proof of payment.

**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](http://www.lsufirst.org) and click on the [webtpa.com](http://webtpa.com) link. All fully completed claim forms and bills should be sent directly to your servicing WebTPA Claim Office.

File your claim forms as described below:

**Hospital Confinement**

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced. 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 with the Claims Administrator within 90 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced. 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.

**It is the responsibility of the patient to ensure that the provider has the necessary insurance coverage information in order to file a claim. If the patient is filing a manual claim on behalf of an out-of-network provider, the patient must include with the manual claim form a copy of a detailed invoice and proof of payment.**
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. Service plan contracts, group practice, individual practice and other prepayment plans.
3. Federal government plans or programs. This includes, but is not limited to, Medicare (refer to Coordination with Medicare following this section) and Tricare.
4. Other plans required or provided by federal or state law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
5. Any individual or family insurance policy or contract or arrangement (including but not limited to automobile accident, no fault or liability insurance) excluding only one which provides solely medical benefits.

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:
  - If the parent with custody has not remarried, the medical plan of the custodial parent will be primary.
  - 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.

If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

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 Coinsurance 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.

- The Plan will pay secondary when a person is eligible for Medicare due to disability, except that the Plan will be primary if the person (or a member of the person's family) who is covered under the Plan by virtue of the person's current employment status with LSU is entitled to Medicare Part A coverage solely as a result of a disability (within the meaning of the Social Security Act) other than ESRD under 42 U.S.C. § 426-1. Enrollment in Medicare is required.
- The Plan will pay secondary when a person is eligible for Medicare due to End Stage Renal Disease (ESRD), except that the Plan will be primary if the person is entitled to Medicare Part A or Part B coverage solely because of ESRD during the 30-month period beginning with the earlier of: (1) the third month after the month in which a regular course of renal dialysis is started, or (2) if a person receives a kidney transplant, the first month he or she is entitled to Medicare. Enrollment in Medicare is required.
- If an Employee or an Employee's spouse is eligible for Medicare, he or she must enroll in Medicare.

In determining a person's rights under Medicare coordination rules, applicable Medicare secondary payment requirements of federal law shall govern.

**Coordination with Medicaid**

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

**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.
- Paid in excess of the Plan's Coinsurance limits prior to meeting the Out-of-Pocket 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.

**Right of Subrogation and REFUND**

**When this provision applies.** The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer, including but not limited to the Covered Person's insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the
Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. This provision expressly abrogates the "make whole" and "common fund" doctrines and similar defenses to the Plan's claims. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his or her designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.
"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

**Recovery from another plan under which the Covered Person is covered.** This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on and approve of all settlements.
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 Citizens Rx 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 1808
  Grapevine, TX 76099-1808
  WebMD/Envoy Payer ID #75261

  Citizens Rx
  1144 Lake Street
  Oak Park, IL 60301
  (888) 471-8620

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.

Claims and Appeals Procedure

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan’s reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual’s eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan’s final decision
is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

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

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

**Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.
In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

- **Notification to claimant of Claim determination**: 72 hours
- **Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:**
  - **Notification to claimant, orally or in writing**: 24 hours
  - **Response by claimant, orally or in writing**: 48 hours
  - **Benefit determination, orally or in writing**: 48 hours
  - **Notification of Adverse Benefit Determination on Appeal**: 72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan’s benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

**Concurrent Care Claims**

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

- **Notification to claimant of benefit reduction**: Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
- **Notification to claimant of rescission**: 30 days
- **Notification of determination on Appeal of Claims involving Urgent Care**: 24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
- **Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims**: As soon as feasible, but not more than 30 days
- **Notification of Adverse Benefit Determination on Appeal for Rescission Claims**: 30 days

**Pre-Service Claim**

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims...
subject to Predetermination of Benefits or pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

- **Notification to claimant of Adverse Benefit Determination**: 15 days
- **Extension due to matters beyond the control of the Plan**: 15 days
- **Insufficient information on the Claim**:
  - **Notification of**: 15 days
  - **Response by claimant**: 45 days
  - **Notification, orally or in writing, of failure to follow the Plan’s procedures for filing a Claim**: 5 days
- **Notification of Adverse Benefit Determination on Appeal**: 15 days per benefit appeal

**Post-Service Claim**

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

- **Notification to claimant of Adverse Benefit Determination**: 30 days
- **Extension due to matters beyond the control of the Plan**: 15 days
- **Extension due to insufficient information on the Claim**: 30 days
- **Response by claimant following notice of insufficient information**: 45 days
- **Notification of Adverse Benefit Determination on Appeal**: 60 days

**Notice to claimant of Adverse Benefit Determinations**

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.
(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan’s internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process. Please contact the Department Health and Human Resources Insurance Assistance Team (HIAT) 888-393-2789.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied
treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the
time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard
to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional
rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be
provided as soon as possible and sufficiently in advance of the time within which a final determination on
Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by
the claimant relating to the Claim, without regard to whether such information was submitted or considered
in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit
Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the
adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a
particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or
appropriate, the fiduciary shall consult with a health care professional who was not involved in the original
benefit determination. This health care professional will have appropriate training and experience in the field
of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was
obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification
of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically
appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service,
    the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis
code and treatment code and their corresponding meanings will be provided to the claimant as soon
as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its
corresponding meaning, and a description of the Plan's standard, if any, that was used in denying
the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the
Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to
such procedures.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable
access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other
similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If
this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion
was relied upon in making the Adverse Benefit Determination and a copy will be provided free of
charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or
Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical
judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process. Please contact the Department Health and Human Resources Insurance Assistance Team (HIAT) 888-393-2789.

The claimant will be entitled to continue coverage pending the outcome of an internal appeal. If the claimant is in an urgent care situation or is receiving an ongoing course of treatment, he or she will be allowed to proceed with expedited External Review at the same time as the internal appeals process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is Experimental or Investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;
(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance ombudsman established under the PPACA. Please contact the Department Health and Human Resources Insurance Assistance Team (HIAT) 888-393-2789.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.
Appeals should be sent to:

WebTPA
P.O. Box 1808
Grapevine, TX 76099-1808
OTHER PLAN INFORMATION

If you need additional information, please contact your Human Resources department. **Agent for Service of Legal Process:**

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

LSU Plan Administrator  
110 Thomas Boyd Hall  
Baton Rouge, LA 70803

**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  
8500 Freeport Parkway, Suite 400  
Irving, TX 75063

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, Citizens Rx 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. Citizens Rx is the Pharmacy Benefit Manager of the Plan and is located at:

Citizens Rx  
1144 Lake Street  
Oak Park, IL 60301  
(888) 471-8620

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, Associate Vice President for Human Resource Management and Plan Administrator  
LSU First Health Plan  
The Louisiana State University System  
304 Thomas Boyd Hall  
Baton Rouge, Louisiana 70803
**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.
Compliance with HIPAA Privacy Standards. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) General. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) Permitted Uses and Disclosures. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) Authorized Employees. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) Updates Required. The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) Use and Disclosure Restricted. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) Resolution of Issues of Noncompliance. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and
(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of LSU's workforce are designated as authorized to receive Protected Health Information from the Louisiana State University System's Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officers.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security
Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.
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 Coinsurance 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 last day of the month in which the Child turns 26 years old;
• 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 in the legal custody of the Employee and who is dependent upon the Employee for support.

Note: Grandchildren legitimately covered as of December 31, 2015, according to the terms of the 2015 Summary Plan Document, will be eligible to remain on the Plan as long as they continue to meet the eligibility requirements outlined in the 2015 Summary Plan Document.

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.”

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 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.

**Covered Person**

The person whose employment at a qualifying agency permits Plan membership for themselves and their Dependents, where applicable. Please note that the Covered Person’s restrictions and requirements also apply to covered Spouses and/or Dependents. Membership based practices are excluded.

**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:
  - Walking
  - Grooming
  - Bathing
  - Dressing
  - Getting in or out of bed
• Toileting
• Eating
• Preparing foods
• 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** –
  - **Natural Children** – the date of birth;
  - **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 in the legal custody of the Employee and who is dependent upon the Employee for support**:
  - The date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or
  - When the Employee obtains a certified copy of signed legal judgment granting the Employee legal guardianship or custody, the date the judgement becomes effective.

**Note:** Grandchildren covered under the Plan prior to January 1, 2016 will remain covered provided the covered Dependent parent remains covered.

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

**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 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

**Family Unit**

The covered Employee and the family members who are covered as Dependents under the Plan.
**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 Information**
Information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

**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 it is determined to be 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 which is engaged primarily in providing inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: It is accredited as a Hospital by the Joint Commission, the
American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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.

**Hour(s) of Service**

Each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the Employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following:

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

**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:
  - Hormone therapy or drugs
  - Artificial insemination
  - In-vitro fertilization
  - 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 Citizens Rx 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.

**Long Term Acute Care (LTAC)**

A long term acute care facility is a specialty-care Hospital designed for patients with serious medical problems that require intense, special treatment for an extended period of time.

**Maximum Out-of-Pocket**

The Out-of-Pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services and includes the Remaining Deductible, coinsurance, copayments and HRA. This limit helps you plan for health care expenses. This limit does not include charges above the MRC, charges for uncovered services or ancillary charges.

**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 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.

For facility services billed on a UB92, successor form or other industry standard form, “Maximum Reimbursable Charge” is determined based on any of the following:

- Fee(s) that are negotiated with the Provider
- A percentage of the billed charges.

“Maximum Reimbursable Charge” is determined and is developed 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.

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 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. Please reference the *Maximum Out-of-Pocket* definition above.

**Out-of-Pocket Maximum**

The maximum amount you will pay in the Coinsurance component. Your percentage of Coinsurance for Covered Medical AND Prescription Drug Expenses accumulate 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 HRA, Deductibles, Covered Medical Expenses, Covered Prescription Drug Expenses, as well as the Covered Medical and Prescription Expenses of your Dependents, contribute towards the Out-of-Pocket Maximum.

**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, 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 home delivery 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.

**Privacy Officer**

A privacy officer is the individual who is responsible for the development and implementation of the entities’ privacy policies and procedures, and is the central point of accountability within the covered entity for privacy-related issues.

**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, other than incidentally, a place for rest, the aged, custodial or educational care.

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:
e. Was participating in the Plan at the time of such former employment ceased;
f. 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;
g. 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.
h. 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
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 113
Certificate of Creditable Rx Coverage 114
Premium Assistance under Medicare and CHIP 117
Civil Rights 118
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.
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.

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).

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Board of Supervisors of Louisiana State University and Agricultural and Mechanical College has determined that the prescription drug coverage offered by LSU First is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two- (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.
What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current LSU First coverage will not be affected. See plan SPD for more information about your prescription drug coverage provisions/options.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with LSU First and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the number listed below and/or visit the LSU First health plan website: www.lsufirst.org

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2015
Contact: LSU HRM
Name of Entity/Sender: LSU First
Phone Number: 1 (225) 578-8200
Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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
**Civil Rights**

LSU First complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LSU First does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

LSU First:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Katti Galatas.

If you believe that LSU First has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Katti Galatas, 110 Thomas Boyd Hall, Baton Rouge, LA 70803, Phone 225-578-1324, Fax 225-578-6571, kgalatas@lsu.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Katti Galatas is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (855) 346-5781 (TTY: (855) 346-5781).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (855) 346-5781 (TTY: (855) 346-5781).


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (855) 346-5781 (TTY: (855) 346-5781)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (855) 346-5781 (TTY: (855) 346-5781) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (855) 346-5781 (TTY: (855) 346-5781).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-346-5781（TTY: 1-855-346-5781）まで、お電話にてご連絡ください。

خیردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب بھی کریں (855) 346-5781 (TTY: (855) 346-5781).


توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشند. با (855) 346-5781 (TTY: (855) 346-5781) تماس بگیرید.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (855) 346-5781 (телетайп: (855) 346-5781).

BY THIS AGREEMENT, the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College on or as of the day and year first below written.

By ____________________________
Plan Administrator

Date ____________________________

Witness __________________________
Date ____________________________