



LSU First
Louisiana State University System Health Plan

Summary Plan Description
Effective July 1, 2010 - June 30, 2011

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EXPRESS SCRIPTS
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Table of Contents

| | |
|--|----|
| LSU FIRST OVERVIEW | 3 |
| LSU FIRST HIGHLIGHTS AND PLAN CHANGES FOR 2010-2011..... | 4 |
| HOW LSU FIRST WORKS | 5 |
| NETWORKS | 14 |
| ELIGIBILITY..... | 19 |
| EFFECTIVE DATE | 26 |
| PRE-EXISTING CONDITION EXCLUSION | 27 |
| ENROLLMENT..... | 29 |
| LEAVE OF ABSENCE..... | 30 |
| COBRA CONTINUATION RIGHTS UNDER FEDERAL LAW | 33 |
| FLEXIBLE BENEFIT PLAN | 38 |
| COVERED SERVICES..... | 39 |
| CONTINUATION OF CARE | 40 |
| COVERED ONLY UNDER HRA..... | 40 |
| COVERED SERVICES UNDER THE PLAN | 40 |
| MEDICAL MANAGEMENT RECOMMENDATIONS | 63 |
| SUPPORT FOR MANAGING YOUR PLAN AND YOUR HEALTH | 64 |
| BENEFIT LIMITS AND EXCLUSIONS UNDER THE PLAN..... | 66 |
| FILING CLAIMS FOR BENEFITS OTHER THAN CRITICAL ILLNESS DIRECT CASH BENEFITS..... | 72 |
| COORDINATION OF BENEFITS (COB)..... | 74 |
| MEDICAL NECESSITY DETERMINATIONS AND APPEALS..... | 78 |
| APPEALS/COMPLAINTS FOR SERVICES OTHER THAN MEDICAL NECESSITY | 83 |
| OTHER PLAN INFORMATION | 85 |
| DEFINITIONS..... | 88 |

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.

The Plan:

- Lets **you** choose your Provider (no referrals required)
- Allows you to spend or save your Health Reimbursement Account for eligible health expenses defined under the Plan as Covered Expenses
- Covers qualifying Preventive Care Services at 100% when utilizing Network Providers/Facilities (or First Choice Providers) and Out-of-Network Providers/Facilities (see the Preventive Care Services section of “Covered Expenses”)
- Provides four coverage levels (so you can pick a coverage level appropriate for you and your family)
 - Employee Only
 - Employee plus Spouse
 - Employee plus Child(ren)
 - Family

As an LSU First Member, you have freedom and control over your health care decisions, along with encouragement to get healthy, stay healthy and save money. (For more information please see the “Support for Managing Your Plan and Your Health” or visit www.lsufirst.org and click on the myCIGNA.com link).

LSU FIRST HIGHLIGHTS AND PLAN CHANGES FOR 2010-2011

CIGNA continues as the Plan Claim Administrator, including the provision of a national Provider network, Employee Assistance Program (EAP), and Wellness programs. Express Scripts Inc. (ESI) continues to provide all prescription drug services, including retail, mail order, and specialty drugs. Managed Care Concepts (MCC) continues to provide all medical management services, including pre-determination of medical necessity, case management, and disease management. Verity HealthNet (VHN) continues to provide First Choice and local network access. The Plan Member Advocate continues to be available to all Plan Members for claim related issues. We are proud to continue to offer the benefits and services contained in this Plan without increasing Plan premium rates this Plan Year.

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

As currently written, these sweeping reforms recently enacted by Congress and signed by the President will not be effective as to the Plan until the Plan Year beginning July 1, 2011.

Group Term Life Insurance

All Employees/Retirees enrolled in the Plan effective July 1, 2010, are eligible for and will be automatically enrolled in a Group Term Life Insurance Policy issued and underwritten by HCC Life Insurance Company. The death benefit has been increased from \$20,000.00 to \$25,000.00 per Employee or Retiree under age 65 enrolled in the Plan. Additionally, HCC is providing Accidental Death and Dismemberment (AD&D) coverage this Plan Year in the amount of \$25,000.00 per Employee or Retiree under age 65 enrolled in the Plan. This coverage is "guaranteed issue" and the "actively at work" provision is not applicable. There is no additional charge for these benefits, nor is medical underwriting or proof of good health required. You will need to complete a Beneficiary Statement upon enrollment with the Plan. This form can be found on <http://www.lsufirst.org> or through your local Human Resource/Benefits Department. Please see the section titled "Group Term Life Insurance" for additional information and the benefit amounts for Employees/Retirees age 65 and older.

Mental Health Parity

In accord with the Mental Health Parity and Addiction Equity Act of 2008, the Plan will provide mental health benefits (including coverage for Autism Spectrum Disorder) and substance use disorder benefits in parity with medical and surgical benefits. Financial requirements and treatment limitations applicable to mental health benefits and substance use disorder benefits are no more restrictive than those requirements and limitations placed on medical and surgical benefits. Charges for Mental Health or Substance Use Disorder accumulate to the out-of-pocket maximum and are paid at 100% once the Out-of-Pocket Maximum has been reached. The Plan Year and Lifetime Maximum benefit includes payment for Physical Therapy, Speech Therapy, and Occupational Therapy drugs, subject to approval by Plan Medical Management.

Coverage for Dependent College Students on Medically Necessary Leave of Absence

Coverage is extended for one (1) year for a dependent child covered as a full-time student if the child loses student status due to a "medically necessary" leave of absence from the school.

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.

Infertility Prescription Drug Benefit

This Prescription Drug Lifetime maximum benefit has been increased from \$5,000 to \$10,000.

HOW LSU FIRST WORKS

LSU First offers two Plan options, each with a lifetime maximum of \$5,000,000 in benefits. **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 two separate components:

1. Deductible
2. Co-Insurance

1. The Deductible

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

Overview of the HRA

The LSU System funds your HRA at the beginning of each Plan Year (7/1).

The HRA pays for 100% of Covered Expenses from any Provider as of the date of service until the HRA is exhausted.

HRA allocated for Effective Date of July 1, 2010 (Beginning of the Plan Year)

| <i>Coverage Category</i> | <i>HRA</i> | |
|--------------------------|-----------------|-----------------|
| | <i>Option 1</i> | <i>Option 2</i> |
| Employee Only | \$1,000 | \$1,000 |
| Employee plus Spouse | \$1,500 | \$1,500 |
| Employee plus Child(ren) | \$1,500 | \$1,500 |
| Family | \$2,000 | \$2,000 |

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 (see chart below). HRA Rollover will be applied to your Remaining Deductible and Co-Insurance, if available. Rollover funds will not be used to pay for generic drugs or First Choice Providers, but will be used for other Covered Expenses, such as In-Network and Out-of-Network services.

Your HRA Rollover and new allocations of HRA, may not exceed the following amounts in a Plan Year:

| <i>Coverage Category</i> | <i>HRA Maximum</i> |
|--------------------------|--------------------|
| Employee Only | \$4,000 |
| Employee plus Spouse | \$6,000 |
| Employee plus Child(ren) | \$6,000 |
| Family | \$8,000 |

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

IMPORTANT NOTE: The HRA and Flexible Spending Accounts

While your HRA is similar to a flexible spending account in a cafeteria plan, they are not the same thing—and 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 can't 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

The Remaining Deductible amount is your Deductible less your HRA. After you have exhausted your HRA, you are responsible for paying 100% of Covered Expenses (including medical and pharmacy) up to the amount of your Remaining Deductible. HRA Rollover will be applied to your Remaining Deductible and Co-Insurance, if available.

Covered Expenses for First Choice Providers and generic prescription drugs do not apply to the Remaining Deductible.

If applicable, your HRA will be used to cover certain services not covered by the Co-Insurance. The cost of these services will be added to your Remaining Deductible. You can find a list of these items in the section entitled "Covered Only Under HRA."

Collective Deductible

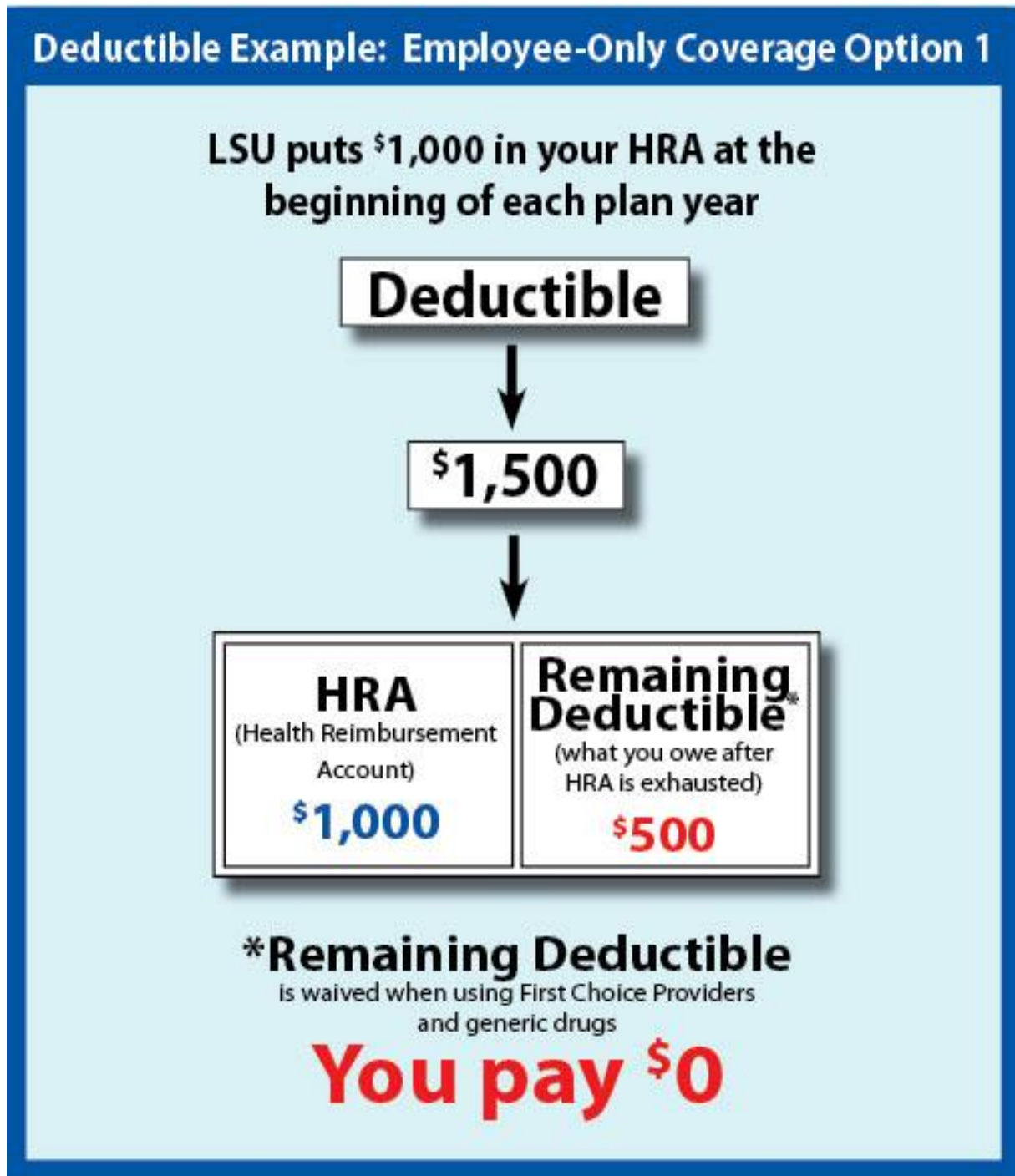
Your Covered Expenses, as well as Covered Expenses of your Dependents, including medical and pharmacy claims, contribute to the Deductible. Co-Insurance is not applicable until the Deductible has been satisfied.

Overview of Deductible Amounts

| Plan Option and Level of Coverage | Deductible Amounts Based on Your Plan Option and Level of Coverage |
|--|---|
| LSU First Option 1 | |
| Employee Only HRA Remaining Deductible Total Deductible | \$1,000 \$500 \$1,500 |
| Employee + Spouse HRA Remaining Deductible Total Deductible | \$1,500 \$750 \$2,250 |
| Employee + Child(ren) HRA Remaining Deductible Total Deductible | \$1,500 \$750 \$2,250 |
| Family HRA Remaining Deductible Total Deductible | \$2,000 \$1,000 \$3,000 |
| LSU First Option 2 | |
| Employee Only HRA Remaining Deductible Total Deductible | \$1,000 \$1,500 \$2,500 |
| Employee + Spouse HRA Remaining Deductible Total Deductible | \$1,500 \$2,250 \$3,750 |
| Employee + Child(ren) HRA Remaining Deductible Total Deductible | \$1,500 \$2,250 \$3,750 |
| Family HRA Remaining Deductible Total Deductible | \$2,000 \$3,000 \$5,000 |

The Chart below illustrates how the Deductible works.

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



Newly Hired Employees

LSU First
2010 – 2011 SPD

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

| New Hire Table for Option 1 | | | | | | |
|-----------------------------|---------------|----------------------|---|----------------------|------------|----------------------|
| Level of Coverage | Employee Only | | Employee + Spouse/ Employee + Children | | Family | |
| EFFECTIVE DATE | HRA | Remaining Deductible | HRA | Remaining Deductible | HRA | Remaining Deductible |
| July 1 st | \$1,000.00 | \$500.00 | \$1,500.00 | \$750.00 | \$2,000.00 | \$1,000.00 |
| August 1 st | \$917.00 | \$458.00 | \$1,375.00 | \$688.00 | \$1,833.00 | \$917.00 |
| September 1 st | \$833.00 | \$417.00 | \$1,250.00 | \$625.00 | \$1,667.00 | \$833.00 |
| October 1 st | \$750.00 | \$375.00 | \$1,125.00 | \$563.00 | \$1,500.00 | \$750.00 |
| November 1 st | \$667.00 | \$333.00 | \$1,000.00 | \$500.00 | \$1,333.00 | \$667.00 |
| December 1 st | \$583.00 | \$292.00 | \$875.00 | \$438.00 | \$1,167.00 | \$583.00 |
| January 1 st | \$500.00 | \$250.00 | \$750.00 | \$375.00 | \$1,000.00 | \$500.00 |
| February 1 st | \$417.00 | \$208.00 | \$625.00 | \$313.00 | \$833.00 | \$417.00 |
| March 1 st | \$333.00 | \$167.00 | \$500.00 | \$250.00 | \$667.00 | \$333.00 |
| April 1 st | \$250.00 | \$125.00 | \$375.00 | \$188.00 | \$500.00 | \$250.00 |
| May 1 st | \$167.00 | \$83.00 | \$250.00 | \$125.00 | \$333.00 | \$167.00 |
| June 1 st | \$83.00 | \$42.00 | \$125.00 | \$63.00 | \$167.00 | \$83.00 |

| New Hire Table for Option 2 | | | | | | |
|-----------------------------|---------------|----------------------|---|----------------------|------------|----------------------|
| Level of Coverage | Employee Only | | Employee + Spouse/ Employee + Children | | Family | |
| EFFECTIVE DATE | HRA | Remaining Deductible | HRA | Remaining Deductible | HRA | Remaining Deductible |
| July 1 st | \$1,000.00 | \$1,500.00 | \$1,500.00 | \$2,250.00 | \$2,000.00 | \$3,000.00 |
| August 1 st | \$917.00 | \$1,375.00 | \$1,375.00 | \$2,063.00 | \$1,833.00 | \$2,750.00 |
| September 1 st | \$833.00 | \$1,250.00 | \$1,250.00 | \$1,875.00 | \$1,667.00 | \$2,500.00 |
| October 1 st | \$750.00 | \$1,125.00 | \$1,125.00 | \$1,688.00 | \$1,500.00 | \$2,250.00 |
| November 1 st | \$667.00 | \$1,000.00 | \$1,000.00 | \$1,500.00 | \$1,334.00 | \$2,000.00 |
| December 1 st | \$583.00 | \$875.00 | \$875.00 | \$1,313.00 | \$1,167.00 | \$1,750.00 |
| January 1 st | \$500.00 | \$750.00 | \$750.00 | \$1,125.00 | \$1,000.00 | \$1,500.00 |
| February 1 st | \$417.00 | \$625.00 | \$625.00 | \$938.00 | \$833.00 | \$1,250.00 |
| March 1 st | \$333.00 | \$500.00 | \$500.00 | \$750.00 | \$667.00 | \$1,000.00 |
| April 1 st | \$250.00 | \$375.00 | \$375.00 | \$563.00 | \$500.00 | \$750.00 |
| May 1 st | \$167.00 | \$250.00 | \$250.00 | \$375.00 | \$333.00 | \$500.00 |
| June 1 st | \$83.00 | \$125.00 | \$125.00 | \$188.00 | \$167.00 | \$250.00 |

HRA and Remaining Deductible for MID-YEAR Allowable Changes

If you make an allowable change to your level of coverage during the Plan Year (see section entitled "Enrollment"), your Deductible will be prorated, based on the remaining number of months in the Plan Year.

When your Level of Coverage changes, your Deductible is prorated and adjusted to your new coverage level minus any amounts used in that Plan Year.

In each of the following examples, additions or reductions to the Deductible assume that no claims were paid for the period of July 1 through December 31.

Example of Increase in Level of Coverage:

On July 1st you are enrolled in Option 1 and your Level of Coverage is Employee Only

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

On January 1st you get married and your new Level of Coverage is Employee + Spouse

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

Example of Decrease in Level of Coverage:

On July 1st you are enrolled in Option 1 and your Level of Coverage is Employee and Spouse

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

On January 1st you get divorced and your new Level of Coverage is Employee Only

- The HRA difference between these two Levels of Coverage is \$500. Based on six months of remaining coverage, the \$500 is prorated for six months and the reduction in HRA is \$250.
- The \$250 is subtracted from your original \$1,500 HRA for a new HRA total of **\$1,250**
- The Remaining Deductible difference between these two Levels of Coverage is \$250. Based on six months of remaining coverage, the \$250 amount is prorated for six months and the reduction in your Remaining Deductible is \$125.
- The \$125 is subtracted from your original Remaining Deductible of \$750, for a new Remaining Deductible of **\$625** for the remainder of the Plan Year.
- Your new Deductible is your new HRA (\$1,250) plus your new Remaining Deductible (\$625), for a total new Deductible of **\$1,875** for the remainder of the Plan Year.
- Any amounts already paid from your Deductible prior to the change in Level of Coverage will be deducted from the Deductible.
- If you exceeded your new, lower HRA amount under the prior, higher level of coverage, you will not be responsible for the excess amount, provided the amounts were properly payable under the HRA, and were incurred prior to the change in coverage level.

IMPORTANT NOTE: However, keep in mind that to the extent your HRA is used to pay for expenses that are only covered under the HRA, those amounts do not apply toward the satisfaction of your Deductible. For a complete listing of such non-traditional Covered Expenses, refer to the section entitled "Covered Only Under HRA."

You can keep track of your Deductible by going online to www.lsufirst.org and clicking on the "Manage Your Account" tab and then the "myCIGNA.com" logo, by calling the toll-free customer service number 1.866.929.LSU1 (1.866.929.5781), or by checking your quarterly statement.

2. Co-Insurance

After you have satisfied your Deductible, you enter the Co-Insurance component of the Plan. You pay a percentage of Covered Expenses until you have reached the Out-of-Pocket Maximum for your Level of Coverage.

Remember: After your HRA is exhausted, LSU First pays 100% for First Choice Providers and generic drugs. Therefore, you pay nothing out-of-pocket for First Choice Providers and generic drugs.

In-Network Co-Insurance

For In-Network Providers, LSU First pays 90% and you pay 10% for both medical and prescription drug Covered Expenses until you meet the Out-of-Pocket Maximum for the Plan Year (see chart below). After you meet the Out-of-Pocket Maximum, LSU First pays 100% of Covered Expenses for the remainder of the Plan Year.

Out-of-Network Co-Insurance

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

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

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

Out-of-Pocket Maximum

To protect you, LSU First has established the maximum amount you will pay in the Co-Insurance component. This is referred to as the Out-of-Pocket Maximum. Your percentage of Co-Insurance for Covered Expenses accumulates to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum varies based on your Level of Coverage and whether or not services are rendered by an In-Network or Out-of-Network Provider (Physicians, Hospitals and Ancillary Providers).

Collective Out-of-Pocket Maximum

Your Covered Expenses, as well as the Covered Expenses of your Dependents, contribute towards the Out-of-Pocket Maximum. An individual cannot have claims covered at 100% until the total Out-of-Pocket Maximum has been satisfied.

IMPORTANT NOTE: Your Co-Insurance payments are simultaneously applied to both the In-Network and Out-of-Network Maximum.

See the chart below for an overview of your maximum Co-Insurance payment for Covered Expenses based on your Level of Coverage and Plan Option. The Out-of-Pocket Maximum resets on July 1st.

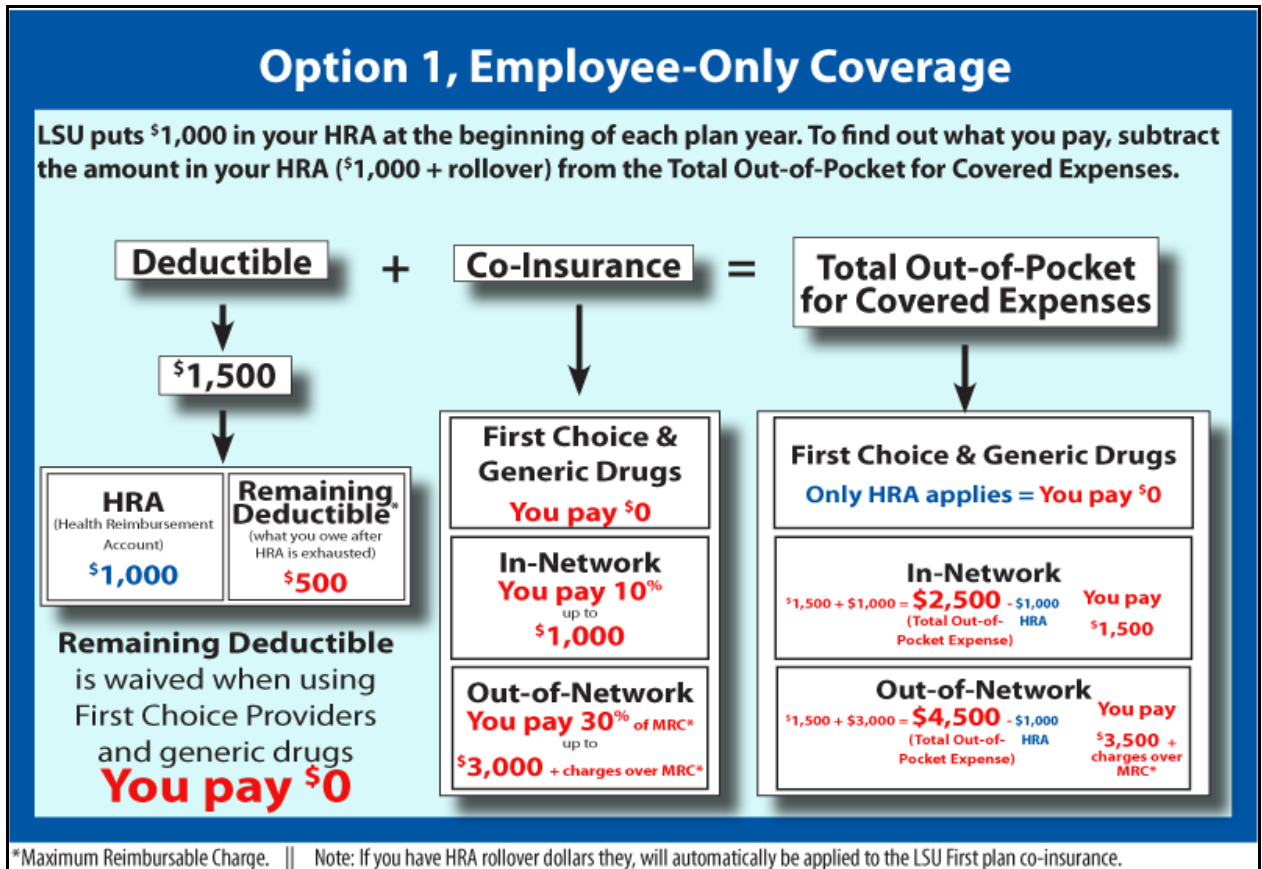
| Co-Insurance and Out-of-Pocket Maximum | First Choice Provider | In-Network Provider (CIGNA Open Access Plus and Verity HealthNet Providers) | Out-of-Network Provider (A Non-Contracted Health Care Provider) |
|---|------------------------------|---|---|
| You Pay | \$0 | 10% of Covered Expenses | 30% of MRC ² for Covered Expenses plus any amount above the MRC² |
| LSU First Option 1 Out-of-Pocket Maximum | | | |
| <i>Employee Only</i> | Not Applicable ¹ | \$1,000 | \$3,000 ³ |
| <i>Employee + Spouse</i> | Not Applicable ¹ | \$1,500 | \$4,500 ³ |
| <i>Employee + Child(ren)</i> | Not Applicable ¹ | \$1,500 | \$4,500 ³ |
| <i>Family</i> | Not Applicable ¹ | \$2,000 | \$6,000 ³ |
| LSU First Option 2 Out-of-Pocket Maximum | | | |
| <i>Employee Only</i> | Not Applicable ¹ | \$1,000 | \$4,000 ³ |
| <i>Employee + Spouse</i> | Not Applicable ¹ | \$1,500 | \$6,000 ³ |
| <i>Employee + Child(ren)</i> | Not Applicable ¹ | \$1,500 | \$6,000 ³ |
| <i>Family</i> | Not Applicable ¹ | \$2,000 | \$8,000 ³ |

¹**After your HRA is exhausted, LSU First pays 100% for First Choice Providers and generic drugs. Therefore, you pay nothing out-of-pocket for First Choice Providers and generic drugs.**

²**Maximum Reimbursable Charge (also known as Usual and Customary)**

³**The Out-of-Pocket Maximums listed above are for Covered Expenses only. For Out-of-Network Providers, LSU First will pay 100% of the MRC once the Out-of-Pocket Maximum is reached. **Charges exceeding the MRC will be the Member's responsibility.****

The chart below is an example of Option 1 Employee Only Coverage. It outlines what you pay when using First Choice, In-Network and Out-of-Network Providers.



NETWORKS

Provider Networks

LSU First provides three Provider Networks to all Members:

- First Choice Provider Network;
- CIGNA Open Access Plus Network (CIGNA OAP); and
- Verity HealthNet Providers.

First Choice Provider Program

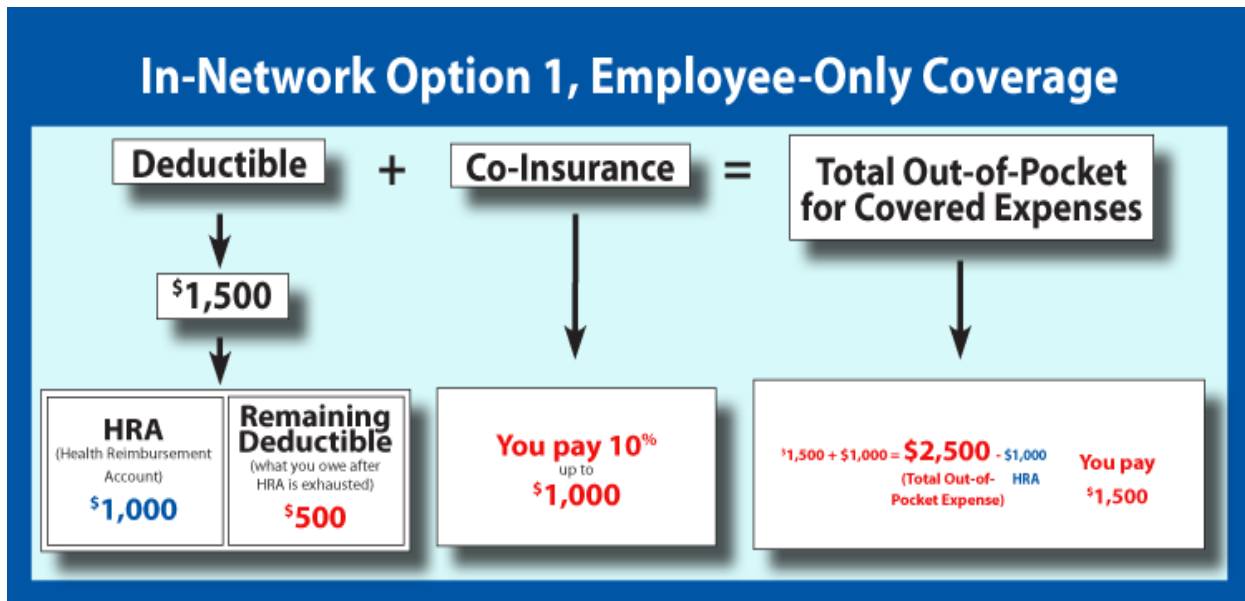
After your HRA is exhausted, LSU First pays 100% when you use a First Choice Provider for Covered Services. The Remaining Deductible (the Deductible less the HRA) and Co-Insurance component are waived when using a First Choice Provider. Your HRA Rollover, if any, will not be used to pay First Choice Providers (see section below entitled "How Your Choice of Provider Affects You").

In-Network Providers

When you access a Provider through either CIGNA (Open Access Plus) or Verity HealthNet, you'll save money. In-Network Providers have agreed to a Contracted Reimbursement Rate. Therefore you can make your HRA go further by using an In-Network Provider. In addition, the Co-Insurance component will pay a greater percentage of Covered Expenses billed by an In-Network Provider.

- *CIGNA Open Access Plus Providers*
 - CIGNA provides wide-ranging nationwide access to Providers.
- *Verity HealthNet Providers*
 - Verity HealthNet offers members robust local-only Provider coverage.

The chart below shows how LSU First pays for In-Network Providers (example based on Option 1 Employee Only Coverage).



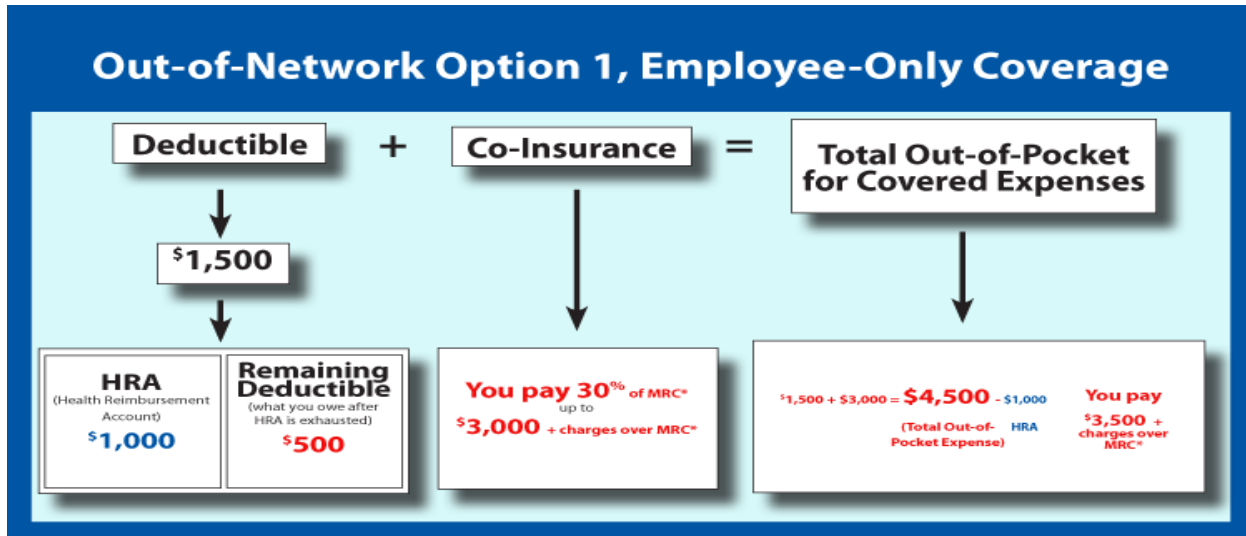
To Locate a Provider

To determine if a Provider is in the networks above, log onto www.lsufirst.org and click on "Search for Providers." You may also call 1.866.929.LSU1 (1.866.929.5781) and a customer service representative can locate a Provider in one of the networks.

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.

The chart below shows how LSU First pays for Out-of-Network Providers (example based on Option 1 Employee Only Coverage).



Visit www.lsufirst.org and click on the "Search for Providers" tab to find a Provider near you.

WARNING:

The fact that a hospital or other facility is an In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based physicians or Providers may not be Contracted Health Care Providers and you may be responsible for charges in excess of Plan payments.

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 Expenses will be reimbursed at 90% of the Maximum Reimbursable Charge (MRC), as determined by the Plan Administrator.

To ensure 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 1.866.929.LSU1 (866.929.5781) and selecting option 3 for Medical Management.

How Your Choice of Provider Affects You

You may seek healthcare services from any Provider. Remember, an Out-of-Network Provider is a Non-Contracted Healthcare Provider. The chart below compares the financial impact of using a First Choice Provider, an In-Network Provider, and an Out-Of-Network Provider.

Assume the following (see chart below):

- You need an outpatient surgical procedure;
- You have Family coverage under Option 1; and
- You have \$1,000 remaining in your HRA and have not met your Remaining Deductible (\$1,000).

| Category | First Choice Provider | In-Network Provider (CIGNA OAP or Verity HealthNet Providers) | Out-of-Network Provider (Non-Contracted Health Care Provider) |
|--|-----------------------|---|---|
| Billed Charge for Procedure | \$10,000 | \$10,000 | \$10,000 |
| Plan Allowed Amount (Covered Expense) | \$5,500 | \$7,000 | \$6,000 |
| Amount Paid from HRA | \$1,000 | \$1,000 | \$1,000 |
| Remaining Deductible (Your portion of the Deductible) | \$0 | \$1,000 | \$1,000 |
| Co-Insurance Paid by You | 0% (\$0) | 10% of Plan Allowed Amount (\$500) | 30% of Maximum Reimbursable Charge (\$1,200) |
| Additional Amount Provider May Bill You (only when you use an Out-of-Network Provider) | \$0 | \$0 | \$4,000 (\$10,000 Billed Charge - \$6,000 Maximum Reimbursable Charge) |
| Your Total Expense for this Outpatient Surgical Procedure | \$0 | \$1,500 (\$1,000 Remaining Deductible + \$500 Co-Insurance) | \$6,200 (\$1,000 Remaining Deductible + \$1,200 Co-Insurance + \$4,000 above the Maximum Reimbursable Charge) |

What If I am Traveling?

If you are traveling and you need medical care, you should contact Customer Service at 1.866.929.LSU1 (866.929.5781) 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.

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 to the Claim Administrator for reimbursement pursuant to applicable Plan provisions. We recommend you pay with a credit card as it automatically adjusts the amount to U.S. dollars.

Specialty Networks

In order to access these services, Members should contact Managed Care Concepts (MCC) at 1.866.929.LSU1 (1.866.929.5781)

- Optum (formerly United Resource Networks or URN) - access to transplant services
- The Assist Group Inc.- access to certain neonatal catastrophic risk management consulting services

- Golden Triangle Specialty Network- access to renal dialysis facilities
- Providers Hemophilia Health Services- access to certain hemophilia risk management consulting services
- Interlink- access to transplant services
- LifeTrac- access to transplant services

Preventive Care

The Plan covers qualifying Preventive Care Services at 100% at a First Choice, In-Network, or Out-of-Network Provider/ Facility. You do not need to spend your HRA for qualifying Preventive Care Services and such services are covered with no Remaining Deductible (your portion of the Deductible) to satisfy. For a complete list of qualifying Preventive Care Services, see the section entitled, "Preventive Care Services". You may receive additional non-qualifying Preventive Care Services; however, any such services will be considered as any other claim and will be processed through your HRA, your Remaining Deductible or Health Coverage.

Personal Websites

First, go to www.lsufirst.org.

This is your entry point for all of your health care needs with news, the Summary Plan Description (SPD) documents, and links to your personal websites such as myCIGNA.com and express-scripts.com, so you can discover all the tools and resources available. You can also find providers on www.lsufirst.org. Look for the links and the new, more helpful First Choice Providers search tool.

Next, you should access the link to myCIGNA.com. You can track your claims, complete a health assessment, review account balances, search for Providers, research cost and quality information, plus much more. To register:

- Click on the myCIGNA.com link on www.lsufirst.org website.
- From myCIGNA.com, select Register in the lower left-hand corner.
- Enter your birth date, home ZIP code and Member ID. Find this number on your new LSU First Member ID card. Call 1.800.284.8346 if you have technical questions about logging in. Combining your Plan features with WedMD® tools, myCIGNA.com gives you access to one of the most extensive resources for health care and medical information available. Once you are registered you can access:

Valuable Information at Your Fingertips

- 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 claim status

Physician Search and Quality Ratings

- Log on to www.lsufirst.org and click on the First Choice Provider link to search for a First Choice Provider. You can also search the CIGNA Open Access Plus (OAP) Provider Directory by clicking on the myCIGNA.com link from the Plan website.
- Review quality and cost efficiency ratings for specialists

Help Before Your Next Procedure

- First, check the Provider's network status.
- With respect to Centers of Excellence, CIGNA identifies facilities that deserve high marks (3 stars) for a particular inpatient procedure based on patient's results and cost. These rankings pertain only to CIGNA Open Access Plus providers.
- Find costs for common inpatient, outpatient and high-tech radiology procedures such as MRI, PET and CT scans
- Click on Hospital Quality and compare facilities by their performance, patients' average length-of stay and cost

Access the link to express-scripts.com. To register:

- Click on express-scripts.com from the link on the www.lsufirst.org website.
- Select Activate Your Account.
- Enter your Member ID number, which you can find on your new LSU First Member ID card.
- Enter your first name, last name, birth date and home ZIP code
- Create a user name (6-20 numbers or letters)
- Create a password (6-20 numbers or letters)
- Create a password challenge question and answer
- Once you are registered, you can review your claims, check prescription drug prices, order refills, check the cost of your prescription medications and generic alternatives, and find pharmacy-specific pricing and options for home delivery.
- Compare drug treatment options for more than 200 common medications. You can better understand side effects, drug interactions and alternatives.
- Order and track home delivery prescriptions or review your prescription drug history.

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. In all cases, eligibility determinations shall be made in accordance with the applicable statutory and regulatory provisions of the Office of Group Benefits); or
2. a full-time Employee, member, or officer of the House of Representatives of the State of Louisiana; or
3. a full-time Employee, member, or officer of the Louisiana State Senate; or
4. a full-time Employee of the Legislative Budgetary Control Council; or
5. a former full-time Employee of the Louisiana State University System; a former full-time Employee, member, or officer of the House of Representatives of the State of Louisiana; a former full-time Employee, member, or officer of the Louisiana State Senate; or a former full-time Employee of 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, the House of Representatives of the State of Louisiana, the Louisiana State Senate, or the Legislative Budgetary Control Council; 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, and the Legislative Budgetary Control Council, in favor of the Louisiana State University System.

Re-Enrollment (Previous Employment for Health Benefits and Life Insurance)

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

Members of Boards and Commissions

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

Legislative Assistants

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

HIPAA Employee Special Enrollment

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

1. Loss of Other Coverage -- Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined because the Employees or Dependents had other coverage which terminated due to:
 - a. Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan Participant; or
 - b. Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer's contributions were ceased for cause or for failure of the individual Participant to make contributions; or
 - c. The Employee or Dependent having had COBRA continuation coverage under a Group Health Plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA.
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. If it is made more than 30 days after eligibility, they will be considered overdue applicants subject to a pre-existing condition limitation.
 - b. 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.
 - c. Special enrollment applicants must complete the "Acknowledgment of Pre-existing Condition" form and "Statement of Physical Condition" form.
 - d. Medical expenses incurred during the first 12 months that coverage for the Special Enrollee is in force under this Plan will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the enrollment date. The provisions of this section do not apply to pregnancy.
 - e. If the Special Enrollee was previously covered under a Group Health Plan, Medicare, Medicaid or other Creditable Coverage as defined in HIPAA, the duration of the prior coverage will be credited against the initial 12-month period used by the Plan to exclude benefits for a pre-existing condition if the termination under the prior coverage occurred within 63 days of the date of coverage under the Plan.

Dependent Eligibility Requirements

The following persons who are enrolled for coverage as Dependents, if they are not also covered as an Employee:

1. The covered Employee's legal spouse;
2. A never married Child from date of birth up to 21 years of age and dependent upon the Employee for support (must be added to coverage by completing appropriate enrollment documents);
3. A never married Child who is a fulltime student under 24 years of age and financially dependent upon the Employee for support;
4. A never married Child of any age who meets the criteria for "Over-Age Dependents" in the section entitled "Over-Age Dependents," 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

If a never-married Dependent Child is incapable (and became incapable prior to attainment of age 21) of self-sustaining employment by reason of mental retardation or physical incapacity, and is dependent upon the covered Employee for support, the coverage for the Dependent Child may be continued for the duration of incapacity.

1. Prior to the Dependent Child reaching age 21, an application for continued coverage with current medical information from the Dependent Child's attending Physician must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above. The Plan Administrator, in its discretion, may consider applications and attending Physician's information submitted after the Child reaches age 21, if the application and information indicate that the Child's incapacity was present prior to the Child reaching age 21, but was not apparent or diagnosed until after the Child reached age 21.
2. Upon receipt of the application for continued coverage, the Plan Administrator may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity as often as he may deem necessary thereafter.

Dependent Verification Requirements for LSU First

To deter fraud and abuse and assure the proper use of public funds and Plan Members' premium dollars, The Office of Group Benefits and LSU First join the majority of public and private health benefit programs by requiring proof that the Dependents covered are legal Dependents of the Employee.

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:
 - a. Certified copy of marriage certificate indicating date and place of marriage
2. Never-married Child under age 21 who is dependent on Employee for support or Natural or legally adopted Child of the Employee/Retiree:
 - 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:
 - a. Certified copy of marriage certificate to spouse and birth certificate listing spouse as natural or adoptive parent

4. Child placed with your family for adoption by agency adoption or irrevocable act of surrender for private adoption who lives in your household and/or will be included as dependent on your federal income tax return for current or next tax year:
 - a. Certified copy of adoption placement order showing date of placement; or
 - b. Copy of signed and dated irrevocable act of surrender
5. Child for whom you have been granted guardianship or legal custody, including provisional custody, who lives in your household and/or will be included as dependent on your federal income tax return for current or next tax year:
 - a. Certified copy of signed legal judgment granting you legal guardianship or custody
6. Grandchild for whom you do not have legal custody or guardianship but who is dependent on you for support and whose parent is a covered Dependent:
 - a. Certified birth certificate or adoption decree showing parent of Grandchild is a Dependent Child and certified copy of birth certificate showing Dependent Child is a parent of Grandchild
7. Never-married Child over age 21 but under age 24 years of age, who is enrolled and attending classes as a full time student and is dependent on you for support 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 submit letter from registrar as proof of full-time student status within 30 days of start date of each semester/quarter
8. Never-married Child age 21 or older who is incapable of self-sustaining employment due to mental retardation or physical incapacity who was covered prior to age 21 or a natural or legally adopted Child of Plan Member:
 - a. Certified copy of birth certificate listing Plan Member as parent; or
 - b. Certified copy of legal acknowledgment of paternity signed by plan member; or
 - c. Certified copy of adoption decree naming Plan Member as adoptive parent
 - d. Must also apply for continued coverage prior to age 21 and provide supporting medical documentation
 - e. Must provide additional medical documentation of Child's condition periodically upon request by the Plan Administrator

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

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

Qualified Medical Child Support Order

Eligibility for Coverage Under a QMCSO

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

Qualified Medical Child Support Order Defined

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

1. the order recognizes or creates a Child's right to receive group health benefits for which a participant or beneficiary is eligible;

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

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

Payment of Benefits

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

Retiree Eligibility Requirements

Eligibility

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

HIPAA Retiree Special Enrollment

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

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

Medicare + Choice/Medicare Advantage Option for Retirees

Retirees who are eligible to participate in a Medicare+Choice/Medicare Advantage plan who cancel coverage with the Plan upon enrollment in a Medicare+Choice/Medicare Advantage plan may re-enroll in the Plan upon withdrawal from or termination of coverage in the Medicare+Choice/Medicare Advantage plan, at the earlier of the following:

1. During the month of November, for coverage effective January 1; or
2. During the next annual enrollment, for coverage effective at the beginning of the next Plan Year.

Tricare for Life Option for Military Retirees

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

Surviving Dependent/Spouse Eligibility Requirements

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.
 - a. The surviving legal spouse of an Employee or Retiree may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a Group Health Plan other than Medicare, or a plan sponsored by the Office of Group Benefits;
 - b. The surviving, never married Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a Group Health Plan other than Medicare or until attainment of the termination age for Children, whichever occurs first;
 - c. Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees and Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits;
 - d. Coverage provided by the Civilian Health and Medical Program for the Uniform Services(CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a Dependent Child.
2. A surviving spouse or Dependent cannot add new Dependents to continued coverage other than a Child of the deceased Employee born after the Employee's death.
3. Participant Employer/Dependent Responsibilities
 - a. It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Plan Administrator within 60 days of the death of the Employee or Retiree;
 - b. The Plan Administrator will notify the surviving Dependents of their right to continue coverage;
 - c. Application for continued coverage must be made in writing to the Plan Administrator within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;
 - d. Coverage for the surviving spouse under this section will continue until the earliest of the following:
 - i. Failure to pay the applicable premium timely;
 - ii. Eligibility of the surviving spouse under a Group Health Plan other than Medicare.
 - e. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:
 - i. Failure to pay the applicable premium timely;
 - ii. Eligibility of the surviving Dependent Child for coverage under any Group Health Plan other than Medicare; or
 - iii. The attainment of the termination age for Children.
4. The provisions of paragraphs 1 through 3 in this subsection are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

Change of Classification

The Plan Member must notify the Plan Administrator when a Dependent is added to or deleted from the Plan Member's coverage that results in a change in the class of coverage. 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 the Plan Administrator of any change in classification of coverage that affects the Employee's contribution amount. If failure to notify is later determined, it will be corrected on the first day of the following month.

Termination of Coverage

Employee and Retired Employee Coverage

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

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

Dependent Coverage Only

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

EFFECTIVE DATE

Employee Effective Dates of Coverage (New Employee and Transferring Employee)

Coverage for each Employee who completes the applicable Enrollment Form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

1. Coverage will be effective the 1st of the month following the first full calendar month of employment. For example, an Employee hired on July 1st will have an effective date of August 1st; an Employee hired on July 18th will have an Effective Date of September 1st.
2. Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will be considered a late applicant.
3. An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the Employee will be considered a late applicant.

Employee/Dependent Date of Coverage for Late Applicants

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

The terms of the following paragraphs apply to Late Applicants. The effective date of coverage will be:

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

Dependent Effective Date of Coverage

1. Dependents of Employees -- Coverage will be effective on the date the Employee becomes eligible for Dependent Coverage.
2. Dependents of Retirees -- Coverage for Dependents of Retirees will be effective on the first day of the month following the date of retirement if the Employee and his Dependents were covered immediately prior to retirement.

Coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement will be effective on the date of marriage for new spouses, the date of birth for newborn Children, or the Date Acquired for other classifications of Dependents. Application must be made within 30 days of the date of eligibility for coverage.

Retiree Effective Date of Coverage

Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions (for example, if retired July 15, coverage will begin August 1).

PRE-EXISTING CONDITION EXCLUSION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer must issue a "Certificate of Creditable Coverage," in writing, free of charge:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a Certificate of Creditable Coverage before losing coverage; or
- if you request a Certificate of Creditable Coverage up to 24 months after losing coverage.

"Creditable Coverage" means health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any health coverage provided by a governmental entity;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit plan under the Peace Corps Act.

If you or your eligible Dependents were covered by any of the above plans before first becoming covered by this Plan, you should have received a Certificate of Creditable Coverage when that plan's coverage ended.

You may request a Certificate of Creditable Coverage under this Plan by contacting the Plan Administrator.

Benefits for the treatment of a Pre-existing Condition are excluded unless you have had Creditable Coverage for 12 months.

This exclusion does not apply to newborn Children or newly adopted Children. This exception for newborn and adopted Children no longer applies after the end of the first 63-day period during which the Child has not had Creditable Coverage.

Pre-existing Condition – a Pre-existing Condition occurs when you or your eligible Dependent receives medical care or has been diagnosed or treated for any Sickness or Injury within six months before coverage under this Plan begins. A Pre-existing Condition does not include Pregnancy. Genetic information is not an indicator of a Pre-existing Condition, if there is not a diagnosis of a condition related to the genetic information. If you have Creditable Coverage, you or your Dependent will be eligible to receive Plan Benefits for a Pre-existing Condition. Creditable Coverage is defined above.

If you have Creditable Coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan. Without evidence of Creditable Coverage, Plan benefits for the treatment of a pre-existing condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

New Employees

1. The terms of the following paragraph apply to all eligible Employees and their Dependents whose employment with a Participating Employer begins on or after July 1, 2001.
2. The Plan may require that such applicants complete a "Statement of Physical Condition" form and an "Acknowledgment of Pre-existing Condition" form.
3. Medical expenses incurred during the first 12 months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately prior to the enrollment date of coverage. The provisions of this section do not apply to pregnancy.
4. If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid, or other Creditable Coverage, credit will be given for previous coverage that occurred without a break for 63 days or more for the duration of prior coverage against the initial 12-month period. Any coverage occurring prior to a break in coverage 63 days or more will not be credited against a pre-existing condition exclusion period.

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. You must sign and return this form to your Human Resources Management Department within 30 days of your date of hire. Also, you must enroll any eligible Dependent(s) within 30 days of your date of hire.

Annual Enrollment

Unless you are otherwise notified, your participation in the Plan will continue each year (unless you change it). However, during Annual Enrollment held every April, you can elect coverage if you previously declined it, or change your coverage level for the following Plan Year effective July 1st.

Late Applicants

1. The Plan will require that all Late Applicants complete a "Statement of Physical Condition" form and an "Acknowledgement of Pre-existing Condition" form.
2. Medical expenses incurred during the first 12 months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a Pre-Existing Condition (a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the enrollment date of coverage). The Pre-Existing Condition provisions of this section do not apply to pregnancy or to Children under age 19..
3. If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid or other Creditable Coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred continuously for 63 days or more for the duration of prior coverage against the initial 12-month period. Any coverage occurring prior to a break in coverage 63 days or more will not be credited against a pre-existing condition exclusion period.

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 Plan Administrator 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 Plan health and life plans.

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

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

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your

Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leave of absence of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leave of absence of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits

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

You and your Dependents will be subject to only the balance of a Pre-Existing Condition waiting period that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, all Plan limitations and exclusions will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a Pre-Existing Condition waiting period will be waived.

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

Military Service Relief Act

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

Family and Medical Leave Act (FMLA)

Any provisions of this Plan that provide for: (a) continuation of coverage during a leave of absence; and (b) reinstatement of coverage following a return to Active Employment are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

Continuation of Health Insurance During Leave

Your coverage will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an Eligible Employee under the terms of that Act.

The cost of your coverage during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

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

You will not be required to satisfy any Eligibility or benefit waiting period or the requirements of any Pre-existing Condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

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.

COBRA CONTINUATION RIGHTS UNDER FEDERAL LAW

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the last day of the calendar month from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours to less than Full-Time employment.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the last day of the calendar month from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death
- your divorce or legal separation, or
- for a Dependent Child, failure to continue to qualify as a Dependent under the Plan

Who can elect COBRA Continuation?

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

Who is Entitled to COBRA Continuation?

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

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period

discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent Child, failure to continue to qualify as a Dependent under the Plan.

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

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

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Participant Employer within 60 calendar days from the end of the month from which any of the following qualifying events occurred:

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

Also refer to the section titled "Disability Extension" below for additional notice requirements.

Notice must be made in writing and must include:

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

Disability Extension

For purposes of eligibility for continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy, based upon your residual functional capacity, age, education, and work experience.

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be disabled under Titles II or XVI of the SSA or by the Plan Administrator, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

1. the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
2. failure to pay the required premium within 30 calendar days after the due date;
3. the Employer ceases to provide a Group Health Plan for its Employees;
4. after electing COBRA continuation coverage, a qualified beneficiary first enrolls in Medicare (Part A, Part B, or both);
5. after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of:
 - a. the end of the applicable maximum period;
 - b. the date the pre-existing condition provision is no longer applicable; or
 - c. the occurrence of an event described in one of the first three bullets above; or
 - d. any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Notification Requirements

Initial Notice

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

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

Notice by Participant Employer

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

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

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

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premiums. The notice will also include instructions for electing

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

Acquiring a New Dependent

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage.

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

Other Coverage that May be Available Following Expiration of Continuation Coverage

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

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 premium rates.

COVERED SERVICES

The chart below provides an overview of how Covered Services are paid (Covered Expenses) under the Plan.

| | Covered Expense | | |
|--|--|---|--|
| | First Choice Provider | In-Network (CIGNA Open Access Plus or Verity HealthNet) | Out-of-Network (Non-Contracted Providers) |
| Lifetime Maximum (includes Medical and Pharmacy) | \$5,000,000 | | |
| Covered Service (see list below) | <p>Total Payment from Plan and Member:</p> <p>HRA payment: 100% of Contracted Reimbursement Rate until exhausted</p> <p>Member payment: \$0</p> <p><u>Remaining Deductible:</u> not applicable</p> <p><u>Co-Insurance:</u> not applicable</p> | <p>Total Payment from Plan and Member:</p> <p>HRA payment: 100% of Contracted Reimbursement Rate until exhausted</p> <p>Member payment: (see below)</p> <p><u>Remaining Deductible:</u> if HRA exhausted, 100% of Contracted Reimbursement Rate up to balance of Remaining Deductible</p> <p><u>Co-Insurance:</u> After Deductible is satisfied, 10% of Contracted Reimbursement Rate, subject to certain exceptions¹</p> | <p>Total Payment from Plan and Member:</p> <p>HRA payment: 100% of Maximum Reimbursable Charge (MRC) until exhausted</p> <p>Member payment: (see below)</p> <p><u>Remaining Deductible:</u> if HRA exhausted, 100% of MRC up to balance of Remaining Deductible</p> <p><u>Co-Insurance:</u> After Deductible is satisfied, 30% of MRC, subject to certain exceptions²</p> <p>Additional Member Liability: Any balance remaining in excess of MRC</p> |

The following sets forth in summary fashion Plan Covered Services, subject to the Definitions set forth above.

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."

LSU First covers a wide range of medical and pharmacy services as noted below. Your level of payment may depend on the network status of the Provider you choose as well as which component of the Plan you are in.

Continuation of Care

If you are in the midst of a cycle of treatment or are in your third trimester of pregnancy when your coverage through the Plan begins, and your provider is not a First Choice or an In-Network provider, you may request that your care continue from your current provider for up to 120 days. If approved by the Plan Administrator, the Plan will pay Covered Expenses at 90% of MRC (subject to the Deductible, Coinsurance and other restrictions), until your cycle of treatment or pregnancy is complete. This benefit is not automatic. For more information on how to qualify please call toll-free 1.866.929.LSU1 (866.929.5781).

Covered Only Under HRA

Expenses incurred after the Effective Date that would be payable under your Remaining Deductible and/or Co-Insurance, or other limitations (lifetime, annual maximum benefits, or other out of pocket limitations) are covered expenses under your HRA. The cost of these services will be added to your Remaining Deductible. In addition, the following is a list of items that are included only as Covered Expenses under your Health Reimbursement Account:

- amounts over Maximum Reimbursable Charge
- amounts or services in excess of any Plan limits
- difference between prescription brand and Generic or Therapeutic Alternative Drugs, if applicable
- amounts not payable because of application of the pre-existing condition exclusion

Covered Expenses must otherwise be allowable as deductions under Internal Revenue Code Section 213, without regard to the limitations contained in Sec 213(a). Amounts reimbursed by the HRA are not eligible for income tax deduction under Section 213. Covered Expenses do not include reimbursement for COBRA premiums under any group health plan maintained by the Employer. An expense is "incurred" when the Participant or beneficiary is furnished the medical items or services giving rise to the claimed expense.

The Internal Revenue Service has specific guidelines that must be followed for many of these items. For more information on a specific benefit, please call 1.866.929.LSU1 (866.929.5781).

| 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. " | |
| Acupuncture | |
| Allergy Injections, Testing and Serum | |
| Ambulance | <ul style="list-style-type: none"> • Ambulance Services for Out-of-Network Providers are paid at 90% of 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 | <ul style="list-style-type: none"> • Outpatient surgery • Outpatient x-ray and laboratory charges |

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.**"

- pre-admission testing
- Short-term Rehabilitative Therapy (Physical Therapy, Speech Therapy, and Occupational Therapy), when provided by a licensed therapist
 - Plan Year Maximum is limited to a combined total of 60 days per Plan Year for all therapies

Anesthesia

Blood, Blood Plasma, and Transfusions

- Breast 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

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 up to \$500
 - Additional diabetes self-management training when medically necessary up to \$100 per year and a lifetime limit of \$2,000

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."**

- One pair of diabetic shoes and inserts per year, up to a \$250 Plan Year maximum

Dialysis

Digital Retinal Imaging

Durable Medical Equipment

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

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

Emergency and Non-Emergency Transport, subject to the following:

- Emergency Ambulance Services are paid at 90% of MRC for all Out-of-Network Providers
- 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

Warning

The fact that a hospital or other facility is an In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based physicians or Providers may not be Contracted Health Care Providers.

Family Planning Services

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

Genetic Testing, subject to the following:

- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact

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.**"

treatment options

- Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered:
 - When either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease

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

Hearing Aids, subject to the following:

Whether external or implantable or any related expenses, except that hearing aids prescribed for minor Children and adults will be covered if the hearing aids are fitted and dispensed by a licensed audiologist following medical clearance by a Physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the Child, if applicable, but this benefit will be limited to a maximum of \$2,400.00 per hearing aid per impaired ear every 36 months

Home Healthcare, subject to the following:

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

The Plan covers the following home healthcare expenses (up to the Plan maximums):

- Part-time or occasional care by a licensed nurse
- Intermittent home health aide services
- Services of a medical social worker
- Physical, occupational, speech and inhalation therapy
- Medical supplies and medicines prescribed by a physician
- Services of a nutritionist

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

Home Infusion Therapy, subject to the following:

When ordered by a physician, including:

- Solutions and pharmaceutical additives
- Pharmacy compounding and dispensing services
- Ancillary medical supplies
- Nursing services to:
 - Train you or your caregiver
 - Monitor the home infusion therapy
 - Provide emergency care
 - Handle collection, analysis and reporting of lab tests to monitor response to home infusion therapy, enteral feedings
 - Other eligible home health supplies and services provided during home infusion therapy

Hospice

Hospital Services, including:

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

Warning

The fact that a hospital or other facility is an In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based physicians or Providers may not be contracted health care Providers

Infertility Services, subject to the following limitations:

Infertility 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, not including Plan payments for infertility medications as set forth below.

- Infertility medications (up to a separate \$10,000 Lifetime Maximum in Plan payments) for the following indications:
 - Treatment for infertility, endometriosis, uterine leiomyomata (fibroids)
- Infertility 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

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.

Mammography

Massage Therapy, when determined to be Medically Necessary

Maternity Care, subject to the following:

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

Medical Supplies

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

Mental Healthcare

The Plan covers consultation, diagnosis or treatment of any mental/nervous condition when services are provided by a:

- Hospital
- Physician
- Licensed Consulting Psychologist (LCP)
- Psychiatrist
- Licensed Psychologist (LP)
- Licensed Social Worker
- Mental health professional

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

Mental Healthcare benefits are in parity with Plan medical benefits. In-Network Outpatient Services are paid at 100% of the Contracted Reimbursement Rate

Mental Health Services

Inpatient Mental Health Services

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

Mental Health Residential Treatment Services

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

Mental Health Intensive Outpatient Therapy Program

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

Outpatient Mental Health Services

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

Covered services include, but are not limited to outpatient treatment of conditions such as:

- Anxiety or depression which interfere with daily functioning
- Emotional adjustment or concerns related to chronic conditions, such as psychosis or

depression

- Emotional reactions associated with marital problems or divorce
- Child/adolescent problems of conduct or poor impulse control
- Affective disorders
- Suicidal or homicidal threats or acts
- Eating disorders
- Acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention)
- Outpatient testing and assessment

Substance Use Disorder Treatment

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

Substance Use Disorder Treatment benefits are in parity with Plan medical benefits. In-Network Outpatient Services are paid at 100% of the Contracted Reimbursement Rate

Substance Use Disorder Rehabilitation Services

Inpatient Substance Use Disorder Rehabilitation Services

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

Substance Use Disorder Residential Treatment Services

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

Outpatient Substance Use Disorder Rehabilitation Services

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

Nutritionists, subject to the limitations set forth below:

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

Organ, Bone Marrow, and Tissue Transplants

All transplant services must be pre-approved by the Plan Administrator.

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, subject to the Individual Lifetime Maximum.

All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.

All Transplant services, other than cornea, are payable at 100% when received at Centers of Excellence, as determined by the Plan Administrator. Transplant services, including cornea, when received from Participating Provider facilities other than Centers of Excellence are payable at the In-Network level.

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

Transplant Travel Services

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

- a) Evaluation
- b) Candidacy
- c) Transplant event
- d) Post-transplant care

Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also

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

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

Oxygen and other gases

Physician's Services, which includes

- Physician visits
- In-patient Physician care

Prescription Drug Benefits

Your pharmacy benefit is designed to cover medications 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. The Pre-Existing Condition exclusion does not apply to prescription drug coverage.

The Plan encourages the use of Generic or Therapeutic Alternative Drugs. If Generic or Therapeutic Alternative Drugs are available and you or your Physician selects otherwise, you must pay the difference at the pharmacy between the Generic and brand name drug (this amount will not apply to satisfaction of the Deductible, thus increasing your Remaining Deductible, or the Out-of-Pocket Limit when applicable).

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

If you choose a brand name drug when a generic equivalent is available, the HRA will cover the full cost of the brand name drug. In this instance, your Remaining Deductible will be increased by this amount. Once your HRA is exhausted, you will be responsible for the difference in cost between the brand name drug and the generic equivalent.

Compounded drugs are medications that are formulated by the pharmacist. Often times, pharmacies preparing compounded medications do not accept insurance. In those circumstances, you will have to pay the cost of the compounded medication at the time of service and submit a reimbursement form to Express Scripts, Inc., the Pharmacy Benefit Manager. If the compounded medication is not FDA approved, you will not be reimbursed.

Medically Necessary Low Protein Food Products are covered, up to \$200.00 per month, 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

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 I.D. card presented.

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

Scenario One:

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

Scenario Two:

You do not have HRA funds available, and you have not satisfied your Remaining Deductible. You receive a prescription for a brand name drug that has no generic equivalent. When you go to an In-Network pharmacy, the cost of the brand name drug becomes part of your Remaining Deductible. The Plan will not pay the cost of the brand name drug and the amount will be applied to your Deductible. You will have to pay the entire cost of the brand name drug at the time you purchase your prescription.

Scenario Three:

You have satisfied your Deductible, but not your Co-Insurance. You receive a prescription for a brand name drug that has no generic equivalent. When you go to an In-Network pharmacy, the Plan will pay 90% of the cost of the prescription and you will pay 10% (your Co-Insurance responsibility). The amount you pay will be applied to your Out-of-Pocket Maximum.

Scenario Four:

You have satisfied your Deductible, but not your Co-Insurance. You receive a prescription for a brand name drug that does have a generic equivalent. You may elect the brand name drug over the generic equivalent; however, you will be responsible for the difference in cost between the generic drug and the brand name drug. This difference in cost is not a covered expense and will not apply toward your Out-of-Pocket Maximum.

Scenario Five:

When 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 from your HRA (assuming you have a HRA balance) or from your Co-Insurance (assuming you have depleted your HRA and met your Remaining Deductible (your portion of the Deductible)). You will be reimbursed by the Plan at the *In-Network contracted rate* for a Covered Expense. You are responsible for any difference between the Out-of-Network pharmacy's price and the Plan's level of reimbursement. If you have depleted your HRA balance, and have not met your Remaining Deductible, the cost becomes part of your Remaining Deductible.

HRA Rollover, if any, is not expended in payment of First Choice Providers or generic drugs.

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

Most pharmacies participate in the network. Certain medications may require prior authorization from Express Scripts. To find a pharmacy near you, or to request a claim reimbursement form call the Pharmacy Benefit Manager at 1.866.929.LSU1 (1.866.929.5781) or visit www.lsufirst.org.

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

Specialty/Injectable Drugs Through CuraScript

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

- Access to Specialty Experts dedicated to serving you with a higher level of personal care at substantial savings
- Medical Management Programs to help insure you're taking Medically Necessary and appropriate medications correctly and to provide the support you need to manage your condition
 - Patient care coordinators who will provide comprehensive clinical management

services

- Supplies for administering your medications- such as syringes, needles, and alcohol swabs
- To receive your next supply of specialty medication through CuraScript, call toll free 1.866.848.9870 (Monday-Friday 7 a.m. to 8 p.m. CST and Saturday 8 a.m. to 12 p.m.)

Prescription Drug Benefit Exclusions

Please refer to the Exclusions section of this document for additional exclusions and limitations on the prescription drug benefit.

Preventive Care/Wellness

The Plan covers Preventive Care Services at 100% when you utilize a First Choice Provider, In-Network Provider/Facility or Out-of-Network Provider/Facility, — with no Remaining Deductible (your portion of the Deductible) to satisfy and no need to use your HRA.

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

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

Preventive Care Services/Wellness Benefits include:

Well-Child Care

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

Well-Adult Care

- Routine Exams and Office Visits
 - One visit every 3 years from age 16 to age 40 years for men
 - Four visits every 3 years from age 16 to age 40 years for women
 - One visit every 2 years from age 40 to age 50 years for men
 - Three visits every 2 years from age 40 to age 50 years for women
 - Annual visits from age 50+ years for men

- Two visits annually from age 50+ for women
- Well-woman visit annually in addition to the annual exam schedule above.
- Immunizations
 - Tetanus / Diphtheria (Td) Booster once every 10 years
 - Tetanus, diphtheria, and acellular pertussis (Tdap) may substitute one dose of (Tdap) for (Td) for persons age 18 years up to age 65 years;
 - Influenza Vaccination (flu shot) annually
 - Pneumococcal Vaccination (Pneumovaz) one dose for persons 65 years and over
 - Meningococcal conjugated vaccine (MCV4), one dose for college freshmen living in dormitories
 - Shingles vaccine, one dose per year for persons 60 years and over
 - Seasonal Vaccinations Administered "in-pharmacy" at ESI Participating Pharmacies
- Screenings
 - 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.
 - Cholesterol screening including triglycerides, LDL, HDL, annually for men age 35 years and over and women age 45 years and older
 - Mammograms, as set forth below:
 - a single baseline mammogram for women ages 35 through 39;
 - a mammogram every 24 months for women ages 40 through 49, or more frequently, if recommended by a physician;
 - one mammogram every 12 months for women age 50 or older.
 - Pap Smear and Routine Pelvic Exam once per Plan Year, as appropriate by age
 - Bone density test annually for osteoporosis for women age 50 years and over
 - Colorectal Cancer Screenings as shown below:
 - Fecal occult blood test (FOBT) one test each Plan Year for persons age 50 years and older;
 - Digital rectal examination (DRE) and prostate specific antigen (PSA) test, one per Plan Year for persons age 40 years and older;
 - Colonoscopy once every 10 years beginning at age 50 years;
 - Flexible sigmoidoscopy once every 5 years for persons age 50 years and older; in combination with a double contrast barium enema (DCBE) once every five years for persons age 50 years and older;

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

- Effective Seasonal Vaccinations are Covered Services under the Plan. Although Seasonal Vaccinations are covered under your Preventive Care Benefit and the medical portion of the Plan, Members electing to receive seasonal vaccinations "in-pharmacy" at ESI participating pharmacies will be able to do so. You will not pay anything out of pocket for the below listed seasonal vaccines *provided* the vaccinations are received at an ESI Participating Pharmacy, *and provided* that the vaccination is received on or after November 15, 2009. The Plan will reimburse ESI for the cost of the "in-pharmacy" vaccines in accordance with the following schedule:
- The Plan will reimburse ESI for the vaccinations at the lower of:
 - a) The combined ingredient cost, dispensing fee (if any) and administration fee (if any) that the Participating Pharmacy generally charges an individual paying cash, without coverage for prescription drug benefits.
 - b) see chart below

| | ESI Participating Pharmacy INFLUENZA | ESI Participating Pharmacy PNEUMONIA | ESI Participating Pharmacy H1N1 |
|-------------------------------|---|---|---|
| Ingredient Cost + | Participating Pharmacy ingredient cost as set forth in the Agreement* | Participating Pharmacy ingredient cost as set forth in the Agreement* | Pass Through (Actual cost of the ingredient to the Participating Pharmacy) |
| Dispensing Fee + | Participating Pharmacy Dispensing Fee as set forth in the Agreement | Participating Pharmacy Dispensing Fee as set forth in the Agreement | Participating Pharmacy Dispensing Fee as set forth in the Agreement |
| Vaccine Administration | \$20.00 | \$20.00 | The lesser of \$20.00 or the maximum amount reimbursed by Medicare for the date on which and the geographic region in which the vaccine is administered |

It is important to note that any services that fall outside of the Well-Child Care and Well-Adult Care listed above, including all prescriptions, will not be eligible under this Preventive Care Services benefit but may be payable as Covered Services. In addition, any of the above Well-Child Care or Well-Adult Care services that are received in excess of the identified schedule may be covered as HRA-Only expenses (see section below entitled "Covered Services").

For more information about Preventive Care and wellness-related products, visit www.lsufirst.org and click on the "Manage Your Account" tab and then on the myCIGNA icon.

Prosthetic appliances, subject to the following exclusions:

External Prosthetic Appliances, subject to the following:

- Initial purchase and fitting of External Prosthetic Appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect
- Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician
- External Prosthetic Appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints
- Coverage for replacement of external prosthetic appliances and devices is limited to the following:
 - Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
 - Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
 - No more than once every 24 months for persons 19 years of age and older
 - No more than once every 12 months for persons 18 years of age and under.
 - Replacement due to a surgical alteration or revision of the site.
 - Excludes penile and testicular prostheses
 - Orthoses and Orthotic Devices (includes splints and braces)
 - Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.
- Coverage is provided for preparation, fitting and basic additions (such as bars and joints) for the following:
 - Rigid and semirigid custom fabricated orthoses
 - Semirigid prefabricated and flexible orthoses

- Rigid prefabricated orthoses including
- Custom foot orthoses are only 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.
- The following are specifically excluded orthoses and orthotic devices:
 - Prefabricated foot orthoses;
 - Cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
 - Copes scoliosis braces
 - Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
 - Orthoses primarily used for cosmetic rather than functional reasons; and
 - Orthoses primarily for improved athletic performance or sports participation.

Pulmonary Rehabilitation

Radiation Therapy, including x-ray and radio isotope treatment

Reconstructive Surgery
 Charges made for reconstructive surgery limited to the following:

- Reconstructive surgery following a covered mastectomy;
- Surgery to repair a defect caused by an accidental injury resulting in a functional impairment;
- Reconstructive surgery related to or following surgery that was needed due to an injury, sickness, or other disease of that part of the body; and
- Cosmetic or reconstructive surgery to repair a Dependent Child's congenital or developmental defect.

Rehabilitation Hospital and Sub-Acute Facility (excluding facilities for treatment of Mental Illness or Substance Use Disorder)

- Plan Year Maximum: Limited to total of 90 days per Plan Year regardless of the Provider's network status

The Plan pays up to the benefits shown in the table entitled "Covered Expense" above while the patient is confined as a bed patient in a rehabilitation hospital or a sub-acute facility as long as:

- 24-hour-a-day nursing care is necessary for recuperation from the injury or illness; and
- The care is ordered and approved by a physician and is not custodial care; and
- Such confinement takes the place of a hospital confinement or immediately follows a hospital confinement for the same illness.

Covered Expenses include the facility's charge for a semiprivate room and all other eligible services and supplies provided by the facility when the patient is entitled to room and board allowance. Benefits are limited to 90 days per Plan Year of inpatient care.

Short-term Rehabilitative Therapy (Physical Therapy, Speech Therapy, and Occupational Therapy), when provided by a licensed therapist

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|--|
| <ul style="list-style-type: none"> Plan Year Maximum: Limited to a combined total of 60 days per Plan Year for all therapies <p>Short-term Rehabilitative Therapy, subject to the following:</p> <ul style="list-style-type: none"> 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. <p>The following limitations apply to Short-term Rehabilitative Therapy and Chiropractic Care Services:</p> <ul style="list-style-type: none"> 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. |
| <p>Skilled Nursing Facility, subject to the following:</p> <ul style="list-style-type: none"> Plan Year Maximum: Limited to total of 120 days per Plan Year, regardless of the Provider's network status <p>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:</p> <ul style="list-style-type: none"> 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. <p>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.</p> |
| <p>Speech Therapy</p> <ul style="list-style-type: none"> To restore speech lost due to a congenital condition for which corrective surgery cannot be performed due to injury or illness |
| <p>Surgical care</p> <ul style="list-style-type: none"> 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.) |
| <p>TMJD/ TMJS Surgical and Non-Surgical</p> <ul style="list-style-type: none"> Provided on a limited, case by case basis. Orthodontic treatment is excluded. Appliances are covered when deemed medically necessary by Plan Medical Management. |
| <p>Urgent Care Services</p> <ul style="list-style-type: none"> Urgent Care Services for Out-of-Network Providers are paid at 90% of MRC. <p style="text-align: center;">Warning</p> <p style="text-align: center;">The fact that a hospital or other facility is an In-Network facility does NOT mean that all of the Providers furnishing services at that facility are In-Network Providers. Facility-based physicians or Providers may not be Contracted Health Care Providers</p> |
| <p>Virtual colonoscopy, subject to the following:</p> <ul style="list-style-type: none"> When performed in connection with diagnostic testing only |
| <p>Wigs, subject to the following:</p> <ul style="list-style-type: none"> When needed for hair loss due to cancer or alopecia areata |

Additional Plan Benefits

Critical Illness Direct Cash Benefit

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

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

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

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

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

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

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

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

Additional Occurrence and Re-Occurrence Benefit

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

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

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

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

Schedule of Covered Critical Illness Benefits

| | First Diagnosis Benefit | Re-occurrence Benefit | Additional Occurrence Benefit |
|--------------------------------|-------------------------|-----------------------|-------------------------------|
| Invasive Cancer | \$5,000 | \$5,000 | \$5,000 |
| Myocardial Infarction | \$5,000 | \$5,000 | \$5,000 |
| Kidney (Renal) Failure | \$5,000 | \$5,000 | \$5,000 |
| Stroke | \$5,000 | \$5,000 | \$5,000 |
| Organ Transplant | \$5,000 | \$5,000 | \$5,000 |
| Coronary Artery Bypass Surgery | \$5,000 | \$5,000 | \$5,000 |

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

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

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

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

All Covered Critical Illnesses

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

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

Invasive Cancer

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

Myocardial Infarction

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

Kidney (Renal) Failure

The Diagnosis of End Stage Renal Disease must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.

Stroke

The Diagnosis of Stroke must be made by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

Major Organ Transplant includes only the following:

- Allogeneic and syngeneic bone marrow/stem cell
- Autologous bone marrow/stem cell
- Heart and/or lung
- Kidney and/or pancreas
- Liver
- Intestine which includes small bowel, or multiple viscera

Coronary Artery Bypass Surgery

The following are required:

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

Claim Forms

Claim forms will be available on www.lsufirst.org under the "Forms" tab. Completed claim forms must be sent to CIGNA at the address set forth below.

Submit your claims to:
CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

Payment of Claims

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

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

Physical Examination and Autopsy

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

Employee Assistance Program (EAP)

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

EAP Certification Requirements For You and Your Dependents

You or your Dependent must request referrals for any treatment for Employee Assistance Program Clinical Services while not confined in a Hospital. A referral must be requested by you or your Dependent prior to the treatment.

EAP expenses incurred for benefits under this Plan will not include expenses incurred while you or

your Dependents are Confined in a Hospital.

CIGNA Behavioral Health EAP National Care Center

CIGNA Behavioral Health EAP National Care Center is the operating headquarters of the Employee Assistance Program. In addition to administrative personnel it includes a staff of mental health and Substance Use Disorder professionals, Personal Member Advocates, and consultants to assist you with the delivery of EAP services.

EAP Covered Expenses

EAP Covered Expenses for Out-of-Network Providers are limited to the Maximum Reimbursable Charge (MRC) for the items or services furnished, as determined by the Plan Administrator, in accordance with the section entitled "Maximum Reimbursable Charge."

EAP Clinical Services

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

The percentage payable will be as follows:

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

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

EAP Clinical Services Schedule

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

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

Maximum EAP Benefits For You and Your Dependents This Plan Will Pay:

- Outpatient Care, up to 3 visits per presenting issue.

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

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

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

EAP Clinical Services Maximums

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

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

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

- Marital problems
- Alcohol and drug problems
- Depression
- Stress
- Parent and child conflict
- Single parenting
- Aging parents
- Job "burn out"
- Financial/legal concerns
- Death and dying
- Retirement concerns

Group Term Life Insurance

All Employees/Retirees enrolled in the Plan effective July 1, 2009, are Eligible for and will be automatically enrolled in Group Term Life Insurance Policy issued and underwritten by HCC Life Insurance Company, an "A" rated life insurance carrier. The coverage amount has been increased to \$25,000 for Employees/Retirees under age 65. In addition, each Employee/Retiree under age 65 will receive Accidental Death & Dismemberment (AD&D) coverage in the amount of \$25,000. Benefit amounts for Employees/Retirees age 65 or older can be found in the reduction schedule below. This coverage is "guaranteed issue" and "actively at work" provisions are not applicable. There is no charge for this benefit, nor is medical underwriting or proof of good health required. You must complete an HCC Beneficiary Statement. This form can be found on www.lsufirst.org or through your local Human Resource/Benefits Department.

This benefit is for covered Employees/Retirees only. Claims under the HCC policy should be submitted through your local Human Resource/Benefits Department. The HCC policy is convertible to a whole life policy if you (the Employee or Retiree) discontinue your coverage with the Plan. In the event an Employee elects COBRA continuation, your HCC life insurance coverage will cancel on the date specified under the Termination of Coverage subsection found in the Eligibility section contained in this SPD.

The Basic Employee Life and Basic Employee Accidental Death and Dismemberment Insurance will be reduced according to the following schedule for all Employees/Retirees. All reductions are based on the amount of insurance in force immediately prior to the first reduction.

| Benefits reduce to: | At Age: |
|---------------------|---------|
| 65% | 65 |
| 50% | 70 |
| 35% | 75 |
| 15% | 80 |
| 5% | 85 |

The terms, conditions, limitations and exclusions of the HCC life insurance policy are different than those of this Plan. We encourage you to review the terms of the HCC life insurance policy. A copy of the policy/certificate of coverage, conversion forms and claim forms can be found at www.lsufirst.org.

Mothers and Newborns 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.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 states that health plans that provide mastectomy coverage must also provide coverage for reconstructive surgery, including:

- Reconstruction of the breast that has been removed;
- Reconstruction of the other breast for a symmetrical appearance; and
- Prosthesis and treatment of any physical complications of the mastectomy.

Coverage must be provided in a manner determined in consultation with the attending physician and the patient.

MEDICAL MANAGEMENT RECOMMENDATIONS

Medical Management is intended to improve the effectiveness of health care by monitoring patient treatment plans and working directly with providers and patients to optimize care. Medical Management is indicated only for patients who have diagnoses which typically require expensive or prolonged treatment, and which can frequently be optimized through a personal assessment and plan of care. The Medical Management process takes into account the needs of the patient, the recommendations and opinions of the patient's health care team, and the cost of alternative methods or processes of care. The Plan Medical Management provider is Managed Care Concepts (MCC). The MCC Medical Management team may include, but is not limited to, one or more case managers, complex care support nurses, health coaches, medical directors, and the patient's health care providers.

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

- Establish a working relationship with the patient's providers and other members of the health care team to assess the patient's needs;
- Identify cost effective alternatives for treating the patient;
- Develop a treatment plan in conjunction with the patient's providers that can maximize the patient's level of functioning and/or minimize the cost of care.
- Make recommendations to the Plan concerning the use of alternative forms of treatment or facilities which are not otherwise covered under the Plan, subject to the limitations hereafter set forth.

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

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

SUPPORT FOR MANAGING YOUR PLAN AND YOUR HEALTH

As a Plan Member, you have freedom and control over your health care decisions, along with encouragement to get healthy, stay healthy and save money. In the next sections, you will learn more about the programs and resources available to you, as well as tips to use your Plan most effectively and economically.

Assess Your Health

Once you have registered on **myCIGNA.com**, be sure to complete your health assessment. Under "I Want To..." on the right side of the screen, select "Take my health assessment."

Your spouse is also encouraged to complete this important online questionnaire, which can help you:

- Identify and monitor your personal health status.
- Obtain a personal analysis of your risk for many preventable and common conditions.
- Review details of your contributing risk factors.
- Access recommended steps for improvement, interactive tools and wellness information.

The Assessment Will Cover:

- Your current health conditions;
- Family health history;
- Lifestyle factors; and
- Basic biometric information, such as weight, cholesterol level and blood pressure. More than 5,000 calculations will take place behind the scenes as you complete the questionnaire, providing you with an accurate assessment of your health status. After you complete your health assessment, you'll receive a list of recommended actions you can take to improve your health. You are encouraged to share this report with your doctor. Based on your assessment responses, you may also receive an email inviting you to participate in an online health coaching program – stress, sleep, nutrition or fitness.

A Personal Health Coach

CIGNA Health Advisors are nurses, dietitians, respiratory therapists and other health care professionals. They will work one-on-one with you. Whether you want to discuss a wellness issue or have a question about how to get the best value for your health care dollars. You'll get the resources and information you need to help you make the decisions that are best for you. Perhaps best of all, you can speak to the same Health Advisor each time you call. Health Advisors are available weekdays from 9 a.m. to 9 p.m., and Saturdays from 9 a.m. to noon in all time zones. You can also expect a welcome call from the Health Advisor team if LSU has your phone number on file, or if you provide your number when you complete the health assessment.

Nurses for Those Dealing With Chronic or Acute/Catastrophic Medical Conditions

Managed Care Concepts (MCC) Chronic Care program provides assistance for Members with specific health conditions such as heart disease, respiratory illnesses, high blood pressure and diabetes. In addition, MCC Case Management Nurses are specifically trained to work with Members who need support and assistance for serious (acute/catastrophic) situations such as cancer, end-stage renal disease, accidents, sickle cell anemia, etc. In both the Chronic Care and Case Management programs, you are assigned a specific nurse so that you are speaking with the same nurse each time. MCC nurses are available weekdays from 7 a.m. - 6 p.m. CT at 1.866.750.2723.

24-Hour Peace of Mind

When you call the 24-hour nurse support line, you will talk with a nurse who can provide confidential answers to your questions, give you helpful home care suggestions, and recommend the appropriate setting for you to receive care. You'll also have access to an extensive audio library with hundreds of topics that affect every Member of your family.

Save With CIGNA Healthy Rewards®

Save on programs and services often not covered through traditional benefit Plans, such as massage therapy, laser vision correction, weight loss programs, and more.

Support and Savings for Those with Diabetes

Getting diabetes testing and insulin pump supplies conveniently when you need them is critical to managing your diabetes and reducing your risk of diabetes-related complications. That's why the Plan offers Global Medical Direct, a leader in the convenient home delivery of diabetes supplies. Because Global Medical Direct is a First Choice Provider, your testing and supplies are covered at 100% after your current year HRA is exhausted. So, there's no out-of-pocket cost to you. Plus, there are no delivery charges.

Other benefits include:

- Regular reorder reminders
- Certified Diabetes Educators available by phone to answer your questions
- Brand name diabetes testing supplies at significant savings
- Coordination with your doctor to make sure you receive the testing supplies you need to follow your doctor's orders
- Free subscription to Health Monitor Magazine

Call 1.800.505.1625 for more information, or to sign up for Global Medical Direct.

When You Need to Speak With a Pharmacist

Express Scripts, your pharmacy benefits administrator, offers you the opportunity to talk with a pharmacist when you have questions about your medications. Just call the Plan's toll-free number, which is 1.866.929.LSU1 (1.866.929.5781).

Fast, Easy Home Delivery

Order your prescriptions online, over the phone or through the mail for fast, convenient home delivery mail service. Save money and order up to a 90-day supply of medication at once. And shipping is free.

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

Support for Those Using Specialty Medications

Members using medications to treat chronic and complex conditions such as rheumatoid arthritis, multiple sclerosis, or growth hormone deficiency, have a great resource in CuraScript, the Express Scripts specialty pharmacy. This service offers patient counseling and education, convenient delivery and free medical supplies, such as such as syringes, needles and alcohol swabs. After you fill your first prescription for a specialty drug at your local retail pharmacy, CuraScript will contact you with more information and details about how to enroll. CuraScript also allows you to choose whether you want your medication delivered to your doctor's office or to your home.

Member Advocate

The Plan Member Advocate is available to all Plan Members regarding claim related issues. The Member Advocate is not employed by LSU, CIGNA, ESI, or MCC. All communications between Plan Members and the Member Advocate are confidential. To access the Member Advocate, contact your local Human Resources Department.

BENEFIT LIMITS AND EXCLUSIONS UNDER THE PLAN

Maximum Reimbursable Charge (MRC)

The Plan pays 70% of Covered Expenses after the Deductible, up to the "Maximum Reimbursable Charge," when an Out-Of-Network Provider/Facility is used.

Benefit Maximums

In addition to the exclusions listed below, refer to the table of Covered Services for the Maximum Individual Lifetime Limit(s) and any Plan Year limit applicable to certain Covered Expenses.

Plan Year limits are met by:

- a) Days/visits/dollar limits paid by your HRA under the Plan, or
- b) Days/visits/dollar limits paid by you as part of your Remaining Deductible, or
- c) Days/visits/dollar limits paid by the Co-Insurance component under the Plan.

Exclusions Under the LSU First Health Plan

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

- Services or supplies used, prescribed, or recommended in connection with any excluded or non-covered treatment or procedure, including, without limitation, any services or supplies related to or arising out of any non-covered treatment or procedure (including any complications arising from the non-covered treatment or procedure), regardless of whether such services or supplies are Medically Necessary
- Treatment, services or supplies that are not Medically Necessary or usual to the treatment of an illness or injury as determined by the Medical Necessity Review Organization retained by the Plan Administrator to make such determinations. This does not apply to Preventive Care Services or other health care services specifically covered under the Plan that are not required to preserve your health
- Amounts in excess of any Co-Insurance component limits, except as specified in the section entitled "Covered Expenses"
- Any illness or injury for which benefits or payments are received (or could be received if claims were made) under any worker's compensation law, Employer's liability law or similar act
- Any care of military service connected conditions for which an Employee incurred charges while on active duty with the armed services of any country or international organization
- Treatment while confined in a state, federal or Veterans Administration hospital for which charges are not imposed
- Health services needed from attempting to commit or committing a felony, or engaging in an illegal occupation
- Services that are prohibited by law or regulations
- Services or confinements ordered by a court or law enforcement officers that are determined by the Medical Necessity Review Organization retained by the Plan Administrator to make such determinations not to be Medically Necessary (an initial court-ordered exam for a Dependent Child under age 18 is considered Medically Necessary)
- Health services performed before the effective date or after the termination of coverage under this Plan
- Any diagnostic inpatient admission if the test can be performed on an outpatient basis
- Any care not recommended and approved by a licensed physician
- Any charges of a physician or health professional for services he or she provides to herself or himself or to any close relative (close relative means spouse, brother, sister, parent, grandparent or Child and the spouse's brothers, sisters, parents, grandparent or Child)
- Services rendered by anyone other than a covered healthcare provider
- Charges for physician's services for injections that can be self-administered
- Vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs
- Non-medical counseling or training services
- Services of the clergy
- Services for reversal of sterilization

- Non-emergency admissions more than 24 hours in advance of a procedure unless specified by your physician
- Personal comfort items while hospitalized such as telephone or television; hospital room and board expenses that exceed the semiprivate room rate unless a private room is approved by Plan Medical Management
- Arch supports, foot orthotics or orthopedic shoes not prescribed by a medical doctor, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a Medically Necessary condition
- Biomechanical evaluation, range of motion measurement and reports, and negative mold foot impression
- Transportation, other than local ambulance service, for a medical emergency to the nearest hospital that can provide care
- Expenses not specifically listed as Covered Expenses under this Plan
- Health professional charges for missed office visits, mailing, shipping and handling expenses, completing any form, or for medical information
- Any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community
- Charges for the treatment of compulsive gambling
- Charges that exceed the allowed amounts and/or the Maximum Reimbursable Charge, except as specifically covered as a HRA Only Covered Expense
- Covered expenses not payable because the applicable Deductible and/or Out-of-Pocket limit has not been met
- Expenses eligible for payment under any other plan, including Medicare
- Sales tax
- Adoption or surrogate expenses
- Ventilator-dependent communication services while confined in a hospital or other medical facility
- Autopsies
- Charges for duplicating and obtaining medical records
- Charges for supplies, services or other items or procedures that are determined to be for a pre-existing condition, but only to the extent that the pre-existing condition exclusion is applicable
- Augmentative communications devices such as keyboards or voice synthesizers in the case of speech impairments
- Breast pumps
- 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:
 - Repair within 90 days and completed within 24 months of accidental injuries to sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan
 - Inpatient and outpatient hospital and anesthesia expenses related to dental work if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition
 - Excision of one or more impacted teeth as performed by doctor of dental surgery (D.D.S.) or doctor of dental medicine (D.M.D.) while coverage is in force
 - For care/treatment rendered as a direct result of radiation therapy to the oral cavity/mucosa, including dental extraction and disposable radiation mouthguard secondary to such radiation therapy.
- Charges for or related to fetal tissue transplants
- Charges related to organ transplants except as specified in the section entitled "Organs, Bone Marrow and Tissue Transplants"
- Charges for artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related services or supplies. Artificial support machines while awaiting a

- human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are covered
- Services, chemotherapy, supplies, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered
 - Charges for cosmetic or reconstructive surgery and related services, except for the following:
 - Reconstructive surgery following a covered mastectomy
 - Surgery to repair a defect caused by an accidental injury resulting in a functional impairment
 - Reconstructive surgery related to or following surgery that was needed due to an injury, sickness, or other disease of that part of the body
 - Cosmetic or reconstructive surgery to repair a Dependent Child's congenital or developmental defect
 - Charges for sex transformation surgery, hormones related to the surgery and any related expenses
 - Charges for surgery or treatment of an experimental or investigative nature as determined by the Plan Administrator (this means the medical use of a service or supply that is still under study and that the service or supply is not yet recognized throughout the provider's profession in the U.S. as safe and effective for the diagnosis and treatment of the illness or injury). This exception includes but is not limited to all phases of clinical trials, all treatment protocols based on or similar to those used in clinical trials; drugs approved by the FDA under its Treatment Investigational New Drug regulation (Note: some investigational services or items in connection with clinical trials may be covered, as required by law. See the section "Legally Required Expenses" for more detail.) This exception does not include drugs that: (a) have been granted treatment investigational new drug (IND) or Group C/treatment IND status; or (b) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (c) for which available scientific evidence demonstrates, that the drug is effective or shows promise of being effective for the disease as determined by the Plan Administrator.
 - Recreational or educational therapy or other forms of non-medical self care or self-help training including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related services or diagnostic testing
 - Hypnotism
 - Phototherapy devices for Seasonal Affective Disorder
 - Gene therapy as a treatment for inherited or acquired disorders
 - Services for, or related to, systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not Medically Necessary
 - Liposuction
 - Full body scans, EBCT (heart scans), except when prescribed for diagnostic rather than preventive or wellness purposes
 - Expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling
 - Travel and/or lodging expenses of a physician or a patient, except as specified in the organ transplant section
 - Products purchased outside of the United States, unless in an unexpected, emergency situation
 - Services provided mainly for rest cures, the ease of a household, or sanitarium care
 - Custodial care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional
 - Services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a physician
 - Private duty nursing services
 - Maternity care for Dependent Children
 - Charges incurred for any surgical procedure or non-surgical procedure aimed at alleviating obesity, including morbid obesity. These specific procedures include: a) gastric bypass; b) roux-en-Y; c) duodenal switch; d) laparoscopic lap band; or e) any other new or related procedures done for the purpose of weight reduction to eliminate obesity or the co-morbidities of obesity
 - Preexisting conditions, as described in the section entitled "Pre-Existing Condition Exclusion"
 - Wig accessories such as:

- Wig caps, wig stands, brushes, sweat liners, toupee clips, adhesives, shampoos, conditioners, sprays, fresheners, mousses, gels, detanglers, wig tape, wig restorer, etc.
- Enteral feeding formulas, except for the following:
 - 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
 - Oral prescription enteral formulas when considered a sole source of nutrition. Over the counter enteral feeding formulas are not covered when given orally
- The Critical Illness Direct Cash Benefit is subject to the limits described in the Plan and does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:
 - The Employee being under the influence of an excitant, depressant, hallucinogen, narcotic, other drug, or intoxicant unless prescribed by a Physician. This exclusion does not apply if the loss resulted from an act of domestic violence or a medical (including both physical and mental health) condition;
 - Voluntary participation by the Employee in a riot;
 - Any illness, loss or condition specifically excluded from the definition of any Covered Critical Illness;
 - War, whether declared or not
- The Mental Health and Substance Use Disorder Benefits exclude the following:
 - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement
 - Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
 - Developmental disorders (except Autism Spectrum Disorder, as set forth in La. R.S. 22:1050 G.(3)), including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders
 - Counseling for activities of an educational nature
 - Counseling for borderline intellectual functioning
 - Counseling for occupational problems
 - Counseling related to consciousness raising
 - Vocational or religious counseling
 - I.Q. testing
 - Custodial care, including but not limited to geriatric day care
 - Psychological testing on Children requested by or for a school system
 - Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline
- Short-term Rehabilitative Therapy and Chiropractic Care services that are not covered include but are not limited to:
 - Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder
 - Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury
 - Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status
- Chiropractic Care Services excludes the following:
 - Services of a chiropractor which are not within his scope of practice, as defined by state law
 - Charges for care not provided in an office setting
 - Vitamin therapy

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

- The following are specifically excluded from Employee Assistance Program Clinical Services:
 - Services provided by a Non-CIGNA Behavioral Health (CBH) Network provider
 - Services provided by a CBH Network provider who is a member of your family or your Dependent's family
 - Inpatient hospital treatment
 - Counseling services beyond a total of 3 sessions per presenting issue for each of you and your Dependents
 - Charges for unnecessary care or treatment or in connection with experimental procedures or treatment methods
 - Charges for custodial services, education or training
 - Counseling required by law or paid for by any workers' compensation or similar law or by a public program other than Medicaid
 - Services received before your participation in the EAP begins
 - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this policy or agreement
 - Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
 - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorder or developmental articulation disorders
 - Counseling for activities of an educational nature
 - Counseling for borderline intellectual functioning
 - Counseling related to raising consciousness
 - Vocational or religious counseling
 - I.Q. testing
 - Residential treatment
 - Custodial Care, including but not limited to geriatric day care
 - Psychological testing on Children requested by or for a school system
 - Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline
 - For conditions which are:
 - Within the scope of usual medical practice
 - Normally handled by non-mental health/behavioral health and Substance Use Disorder clinicians
 - For charges in excess of the amount which the Provider has agreed to accept for the service

- The following are specifically excluded from Infertility Services Benefit:
 - Reversal of male and female voluntary sterilization
 - Infertility services when the infertility is caused by or related to voluntary sterilization
 - Any experimental, investigational or unproven infertility procedures or therapies

The following are specifically excluded from the Prescription Drug Benefit:

- 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, and influenza vaccines)
- 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 the Express Scripts, the pharmacy benefits administrator
- Growth hormones, except for the following, which require prior authorization from Express Scripts. Contact Express Scripts for more information at 1.866.929.LSU1 (1.866.929.5781):
 - Adults with hypophyseal dysfunction resulting in symptomatic growth hormone deficiency
 - Pediatric human growth hormone deficiency
 - Gonadal dysgenesis (Turner Syndrome)
 - Growth failure secondary to chronic renal failure/insufficiency in Children who have not received a renal transplant
 - Prader-Willi Syndrome
 - Adult growth hormone deficiency syndrome
 - AIDS related cachexia (Serostim only)
 - Small for Gestational Age (SGA) for Children over age two years
- Medical devices or equipment
- Smoking cessation products
- Weight loss medications except for Members whose BMI is 40 or greater, under the care of licensed Physician and is enrolled in an approved weight management program (prior authorization by Plan Medical Management is required)
- Anti-wrinkle medications
- Hair growth and hair removal treatments
- Cosmetic therapies, except for Tretinoin products (e.g. Retin-A) when prescribed for acne reasons up to age 26 years
- De-pigmentation products used for skin conditions requiring a bleaching agent
- Contraceptive implants, diaphragms, and IUD's (covered under medical benefits)
- Yohimbine for erectile dysfunction (not FDA approved for this indication)
- Serums, toxoids, and vaccines (e.g. Lymerix); Gardasil, Rhogam, and Synagis will be covered
- Non-legend medications and OTC equivalents except as approved by the Plan Administrator
- Durable Medical Equipment, except for:
 - Respiratory Therapy Supplies (e.g. Aerochamber, Spacers, Nebulizers)
 - Non insulin syringes
- Diagnostic testing and imaging supplies (e.g. Tubersol used for TB skin test, Tadiopaque 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 Express Scripts, the pharmacy benefits manager.
- Non-prescription or over the counter medications unless approved by the Plan Administrator

Treatment, services, and/or supplies excluded under the Plan may qualify for recommendation and approval for coverage as Alternative Treatment. Please refer to the section entitled "Medical Management Recommendations"

FILING CLAIMS FOR BENEFITS OTHER THAN CRITICAL ILLNESS DIRECT CASH BENEFITS

When you receive care from your health care Provider, you will present your Plan ID card. Your provider should submit a claim for payment directly to CIGNA, 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 CIGNA 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 CIGNA, 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 CIGNA processes your claim is used when deducting from your HRA. This allows your HRA to act like a savings account, available for your use when your claim is paid.

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.lsu.edu and click on the myCIGNA.com link. All fully completed claim forms and bills should be sent directly to your servicing CIGNA Claim Office.

File your claim forms as described below:

Hospital Confinement

If possible, print your CIGNA 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 CIGNA.

During Hospital Confinement

If the medical benefits under this Plan cease for you or your Dependent, and you or your Dependent is Confined in a Hospital on that date, medical benefits will be paid for Covered Expenses incurred in connection with that hospital confinement. However, no benefits will be paid after the earliest of:

- The date you exceed the maximum benefit, if any, shown in the Schedule;
- The date you are covered for medical benefits under another group plan;
- The date you or your Dependent is no longer Hospital Confined; or
- 12 months from the date your medical benefits cease.

The terms of this medical benefits extension will not apply to a Child born as a result of a pregnancy which exists when your medical benefits cease or your Dependent's Medical Benefits cease.

Doctor's Bills and Other Medical Expenses

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

Claim Reminders:

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

Your Member ID number is the ID shown on your Plan identification card.
Your account number is the 7-digit policy number shown on your Plan ID card.

Send claims to:
CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

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.

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 you would be reimbursed 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 are 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.

Coordination with Medicare

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

1. The following applies to Retirees and to covered spouses of Retirees who have become Medicare-eligible before July 1, 2009:
 - a. A Retiree and/or the Retiree's spouse may be eligible for Medicare if the Retiree or Retiree's spouse has sufficient earnings credits.
 - b. If the Retiree or Retiree's spouse did not enroll in Medicare Part B when eligible to do so, the Plan will pay primary as to claims that would otherwise be payable under Part B, provided the employee has paid the applicable premium for Retirees with No Medicare.
2. The following applies to Retirees and to covered spouses of Retirees who have become Medicare-eligible on or after July 1, 2009:
 - a. The Claim Administrator will determine the benefits which would have been payable for eligible charges incurred under the terms of the Plan in the absence of Medicare.
 - b. The Claim Administrator will deduct the benefits payable for such eligible charges under the provisions of Medicare whether or not you are actually covered by Medicare from the amount which would have been payable under the Plan.
 - c. The remaining balance, if any, shall be payable under the Plan, subject to the maximum due under the Plan. The Deductible and Co-Insurance provisions, if any, will be applied before benefits are paid on this balance.
 - d. Because the Claim Administrator will coordinate benefits for all Retirees eligible for Medicare as if such Retiree were covered under Medicare Part A and Part B, you are strongly encouraged to enroll in Medicare Part A and Part B as soon as you are eligible.
3. Regardless of your date of retirement, if you elected Part B coverage and later dropped or lost Part B coverage (i.e. by failure to pay the premium) the Plan will immediately begin to assess you the appropriate premium (Retiree without Medicare Part B). Additionally, any improperly reduced premium you may have paid between the date you dropped or lost Part B coverage and the date of the Plan's discovery of that fact may be recouped by the Plan. See the section entitled "Right of Recovery" detailing the Plan's recoupment rights.

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

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

Right of Recovery

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

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

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

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

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

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

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

Third Party Liability

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

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

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

Subrogation

When a covered person receives a benefit from the Plan for an illness or injury and the covered person is entitled to recover payment for that illness or injury from any third party who may be obligated to pay for such illness or injury, the Plan Administrator is subrogated to all rights of the covered person to recover any payments the covered person is entitled to on account of such illness or injury, to the extent the Plan paid a benefit.

A covered person receiving such payment from the Plan shall sign and deliver all necessary papers to effect and preserve the Plan's right of subrogation and shall not do anything before or after payment is

made by the Plan which would prejudice such subrogation or the Plan's right of recovery from any potentially liable third parties.

The Plan shall be reimbursed for any benefits it paid relating to that illness or injury, up to the full amount of any recovery or payments received by the covered person, the covered person's legal representative or any other person or organization on account of the illness or injury, regardless of how the recovery or payments may be characterized. The Plan shall be reimbursed from any settlement, judgment or other recovery, and may collect from the proceeds of any settlement, judgment or other recovery received or obtained by the covered person, the covered person's legal representative or any other person or organization on account of the illness or injury.

The Plan's rights of recovery may be from a third party, any liability or other insurance covering a third party, medical payments, or any other insurance coverage that are paid or payable, including but not limited to the covered person's own uninsured motorist insurance, underinsured motorist insurance, homeowners insurance, no fault insurance, automobile medical payments insurance, or school insurance.

Priority of Recovery

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

MEDICAL NECESSITY DETERMINATIONS AND APPEALS

Prospective Review

Initial Determinations of Medical Necessity will be obtained from the Medical Necessity Review Organization (MNRO) automatically by the Claim Administrator or the Pharmacy Benefit Manager or its designee at the time of your request for Pre-Authorization (Prospective Review). You and/or your provider will be notified (by the MNRO) of the MNRO's decision. If the retrospective review by the MNRO reveals that the supplies, services, drugs or treatment were not Medically Necessary, no benefits for such supplies, services, drugs or treatment will be payable under this Plan. If you elect to continue with the a hospitalization, course of treatment, level of care or supplies, services, drugs or treatment after you have been notified that the MNRO has determined that it is not Medically Necessary, you (not the Plan) will be responsible for all charges for such supplies, services, drugs or treatment.

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

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

Concurrent Review

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

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

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

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

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

Retrospective Review

The Plan shall have the right to have the MNRO conduct a Medical Necessity review of supplies, drugs or services after they have been furnished (retrospective review). The Plan may obtain a retrospective review of any supplies, services, drugs or treatment. You and/or your provider will be notified if the MNRO determines on retrospective review that any supplies, services, drugs or treatment are not Medically Necessary. If the MNRO determines on retrospective review that such supplies, services, drugs

or treatment were not Medically Necessary, you (not the Plan) will be responsible for all charges for such supplies, services, drugs or treatment.

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

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

Standard Appeals and External Review Procedures

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

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

Informal Reconsideration

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

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

First Level Standard Appeal

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

IMPORTANT NOTE: The request for an Informal Reconsideration does NOT stop the running of the 60 days to appeal. Whether or not you have requested or received an Informal Reconsideration, you MUST initiate your First Level Standard Appeal within 60 days of the adverse determination.

For the adverse determination to be upheld, a physician must concur in the initial denial (adverse determination). If your physician is a specialist, the concurring physician will be of the same specialty as your physician.

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

The written notification will contain the following:

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

Standard Second Level Appeal

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

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

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

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

At the meeting, you have the following rights:

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

The MNRO will notify you of the decision within 5 working days of the completed meeting date. Written notification will include:

- The title and credentials of the appropriate clinical peer affirming an adverse determination.
- A statement of the nature of the appeal and all pertinent facts.
- The rationale for the decision.
- Reference to the documentation used in making the decision.
- The instructions for requesting a written statement of the clinical rationale, including clinical review criteria used to make the determination.
- Notice of the covered person's right to an external review, and instructions for initiating external review

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

decision on Second Level Review, that decision becomes final, and is not subject to further review or appeal.

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

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

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

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

Expedited Appeal

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

Expedited Appeals must be initiated in the same time frame (60 days) as standard appeals.

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

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

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

Expedited External Appeal

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

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

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

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

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

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

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

APPEALS/COMPLAINTS FOR SERVICES OTHER THAN MEDICAL NECESSITY

Notice of an Appeal or Grievance

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

When you have an Appeal or Complaint

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

Start With CIGNA Member Services or Express Scripts Member Services

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

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

1.866.929.LSU1 (1.866.929.5781)

CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

Express Scripts, Inc.
Member Reimbursements
PO Box 66583
St. Louis, MO 63166
ATTN: Claims Department

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

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

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

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

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

Second level pre-service appeal decisions will be communicated to you within 15 days. Second level post-service appeal decisions will be communicated to you within 30 days.

If you are not satisfied with the second level appeal decision, you may request a review by the Plan Administrator. The request for review by the Plan Administrator is voluntary and will not affect your rights to any other benefits under the Plan. No fees or costs are imposed on you if you choose to contact the Plan Administrator after the second level of appeal.

OTHER PLAN INFORMATION

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

Agent for Service of Legal Process

The agent for service of legal process is:

John Lombardi
Louisiana State University System
3810 West Lakeshore Drive
Baton Rouge, LA 70808

Amendment or Termination

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

Capitations and Headings; Singular or Plural Form

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

Claim Administrator

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

CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

You may also contact the Claim Administrator by calling 1.866.929.LSU1 (1.866.929.5781).

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 Advocate

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

Misstatements, Misrepresentation, or Fraud

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

No Employment Rights

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

Pharmacy Benefit Manager

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

Express Scripts, Inc.
Member Reimbursements
PO Box 66583
St. Louis, MO 63166

You may also contact the Pharmacy Benefit Manager by calling 1.866.929.LSU1 (1.866.929.5781).

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:

L. Kenneth Krogstad, Plan Administrator
LSU System Health Plan
The Louisiana State University System
3810 W. Lakeshore Drive
Baton Rouge, Louisiana 70808
225.578.0033
krogstad@lsu.edu

Plan Changes and Termination

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

Plan Sponsor

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

Plan Year

The financial records of the Health Coverage component and the Health Expense Reimbursement Plan are kept on a Plan Year basis beginning on each July 1st and ending on each June 30th.

Rights to Offset Future Payments

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

Right to Recover Payments

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

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

Tax Effect

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

DEFINITIONS

Assistant and/or Co-Surgeon

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 Eligible Health 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.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CIGNA 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 who is dependent upon the Employee for support;
- A Child in the process of being adopted by the Employee through an agency adoption, who is living in the household of the Employee, and is or will be included as a Dependent on the Employee's federal income tax return for the current or following tax year (if filing is required);
- A Child in the legal custody of the Employee, who lives in the household of the Employee and is or will be included as a Dependent on the Employee's federal income tax return for the current or following tax year (if filing is required);
- A Grandchild of the Employee who is not in the legal custody of the Employee, who is dependent upon the Employee for support and whose parent is a covered Dependent. If the Employee

seeking to cover a Grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

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

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.

Co-Insurance

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

Contracted Reimbursement Rate

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.

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 Critical Illness

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

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. For In-Network Providers, Covered Expenses are limited to the Contract Reimbursement Rate set forth in the applicable contract with the Contracted Health Care Provider. Covered Expenses for Out-of-Network Providers are limited to the Maximum Reimbursable Charge (MRC) for the items or services furnished, as determined by the Plan Administrator, in accordance with the section entitled "Maximum Reimbursable Charge."

Creditable Coverage

The period of time that an individual was covered, without a Significant Break in Coverage occurring after the Creditable Coverage and before the Effective Date, under any of the following:

- A Group Health Plan;
- Health insurance coverage;
- Medicare;
- Medicaid;
- Medical and dental care for members and certain former members of the uniformed services, and for their Dependents;
- A medical care program of the Indian Health Services Program or a tribal organization;
- A state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- Any health coverage provided by a governmental entity;
- Any public health benefit program provided by a state, county, or other political subdivision of a state; or
- A health benefit plan under the Peace Corps Act.

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 not in the legal custody of the Employee, but who is dependent upon the Employee for support and whose parent is a covered Dependent:
 - The date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or
 - The date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

Deductible

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

Dependent

Any of the following persons, if they are not also covered as an Employee:

1. Legal spouse of Employee/Retiree.
2. Never-married Child of Employee/Retiree under age 21 who is dependent on Employee for support or duly acknowledged natural or legally adopted Child of the Employee/Retiree.
3. Stepchild of Employee/Retiree.
4. Child of Employee/Retiree 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.
5. Child of Employee/Retiree for whom you have been granted guardianship or legal custody, including provisional custody, who lives in your household and/or will be included as dependent on your federal income tax return for current or next tax year.
6. Grandchild of Employee/Retiree for whom you do not have legal custody or guardianship but who is dependent on you for support and whose parent is a covered dependent.
7. Never-married Child of Employee/Retiree over age 21 but under age 24 years of age, who is enrolled and attending classes as a full time student and is dependent on you for support or a natural or legally adopted Child of Plan Member.
8. Never-married Child of Employee/Retiree age 21 or older who is incapable of self-sustaining employment due to mental retardation or physical incapacity who was covered prior to age 21 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

A legally licensed Doctor of:

- Medicine
- Osteopathy
- Dentistry
- Podiatry
- Chiropractic
- Optometry

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 and Health Maintenance Organization/HMO Enrollment/Change Form (GB-01), unless otherwise specified.

Expense Incurred

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

Experimental or Investigational

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

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

In determining whether a service or supply is Experimental or Investigational, opinions from any of the following may be 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 Appliances

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

First Choice Provider

A Healthcare Provider that has met certain established standards and who has agreed to accept certain fixed fee payments from the Plan for Covered 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 Therapeutic Alternative Drug

A drug which is produced and distributed without a brand name or is a therapeutic equivalent to a brand name medication within that same class. A Generic or Therapeutic Alternative Drug must contain the same active ingredients as the original formulation or an active ingredient within the same therapy class. For purposes of this definition, it can be considered bioequivalent or therapeutically equivalent to the brand name counterpart with respect to pharmacokinetic and pharmacodynamic properties. By extension, therefore, Generic or Therapeutic Alternative Drugs are assumed to be identical in dose, strength, route of administration, safety, efficacy, and intended use. Therapeutic equivalents would be products that are equivalent to another product within the same therapy class used to treat same condition. In most cases, generic products are not available until the patent protections afforded to the original developer have expired.

Genetic Testing

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

Geographic Area

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

Group Health Plan

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

Health Reimbursement Account (HRA)

The account established by the Plan to help fund a portion of the Deductible, based on the level of coverage 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

The Health Insurance Portability and Accountability Act of 1996, and the Regulations promulgated pursuant thereto.

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 Health Care Plan

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

Home Health Care Visit

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

Hospice Care Program

The term Hospice Care Program means:

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

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

The term Hospice Facility means an institution or part of it which:

- Primarily provides care for Terminally Ill patients
- Is accredited by the National Hospice Organization
- Meets standards established by CG
- Fulfills any licensing requirements of the state or locality in which it operates

Hospital

The term Hospital means:

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

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

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- A registered bed patient in a Hospital upon the recommendation of a Physician;
- Receiving treatment for Mental Health and Substance Use Disorder Services in a Partial Hospitalization program;
- Receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HRA Rollover

An HRA balance that is not applied to reimbursement of Eligible Health Expenses in any Plan Year shall be carried forward into the next Plan Year, and may accumulate in a Participant's Health Reimbursement Account throughout a Participant's Period of Coverage

Illness

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

Immediate Family Member

A person who is related to the Employee in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or Child (includes legally adopted or stepchild.)

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

- 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

In-Network Provider

A Contracted Health Care Provider. Please see definition above.

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 (For EAP Clinical Services)

- The term In-Network refers to care which is received from a Participating Provider.
- You are responsible for notifying the EAP National Care Center prior to receiving care.
- Emergency care which is authorized as such by the National Care Center is also considered In-Network.

Invasive Cancer

A disease which is manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. For the purposes of this definition, it does NOT mean the following:

1. Pre-malignant lesions, benign tumors or polyps
2. Leukoplakia
3. Hyperplasia
4. Carcinoid
5. Any tumors in the presence of any human immuno-deficiency virus (HIV)
6. Polycythemia
7. Stage 1 Hodgkin's disease
8. Stage A prostate cancer
9. Duke's stage A colon cancer
10. Intraductal non-invasive breast cancer
11. Stage 0 or 1 transitional cell carcinoma of urinary bladder; and
12. Any skin cancer other than malignant melanoma with a depth of 1mm or deeper or greater than Clark level 2
13. T1N0M0 (TNM Classification System) papillary carcinoma of the thyroid less than 1 cm in diameter

14. Chronic Lymphocytic Leukemia RAI stage 0
15. In-Situ Cancer

Kidney (Renal Failure)

End stage failure which:

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

Low Protein Food Products

Those especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low Protein Food Products do not include natural foods that are naturally low in protein.

Maximum Lifetime Individual Limit

The Plan will pay benefits limited to the Maximum Lifetime Individual Limit. This applies individually to each covered Person and covered Dependent. When benefits in such amount have been paid or are payable under this benefits, all coverage for that person under this benefit will terminate. This term does not mean that benefits under the Plan are guaranteed for a Covered Person's or Covered Dependent's lifetime.

Maximum Reimbursable Charge (MRC)

"Maximum Reimbursable Charge" means the following as applicable to services eligible under the Plan: Covered Expenses per applicable Plan provisions up to the "Maximum Reimbursable Charge" amount. For professional services billed on a CMS 1500, successor form or other industry standard form, "MRC" is determined at the Plan Administrator's discretion based on any of the following:

- Fee(s) that are negotiated with the Provider.
- A fee schedule based on a percentage of the published rates allowed by Medicare for the same or similar service.
- A fee schedule the Plan develops and may amend from time to time.
- A percentage of the billed charges as determined by the Plan Administrator.

For facility services billed on a UB92, successor form or other industry standard form, "Maximum Reimbursable Charge" is determined at the Plan Administrator's discretion based on any of the following:

- Fee(s) that are negotiated with the Provider
- A percentage of the billed charges as determined by the Plan Administrator.

"Maximum Reimbursable Charge" is determined solely by the Plan Administrator and is developed, in the discretion of the Plan Administrator, following evaluation and validation in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications
- As used for Medicare.
- As determined by outside medical consultants pursuant to other appropriate source or determination that we accept.

In addition to all of the above, to assist in the determination of the "Maximum Reimbursable Charge" for a service or supply that is unusual, not provided in the Geographic Area, or provided by a small number of Providers, the Plan Administrator will consider the following:

- The complexity of the service or supply.
- The degree of skill needed.
- The Provider's specialty.
- The range of services or supplies provided by a facility.

Plan fees for similar services in other areas

Medicaid

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

Medicare

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

Medically necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Plan Medical Management Medical Director to be:

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

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 Health Care Provider

Any Provider other than a Contracted Health Care 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."

Organ Transplant

Having undergone surgery as a recipient of a transplant as follows:

- human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or
- whole human organs limited to: heart, lung, liver, or pancreas because of the irreversible end stage failure of such organ.

For the purpose of this definition, Organ Transplant does NOT mean:

- other stem cell transplant; or
- part of an organ transplant .

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 Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the Plan because of any coinsurance.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- non-compliance penalties.
- provider charges in excess of the out-of-network fee schedule.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Participant or Member

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

Participant Employer

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

Participating Provider

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

Physician

The term 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.

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 July 1 and ends on June 30 of the following year.

Prescription Drug Charges

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

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

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 for Medical Insurance

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.

Significant Break in Coverage

That a covered person has a period of 63 or more consecutive days during which such person has no Creditable Coverage.

Skilled Nursing Facility or Extended Care Facility

An institution or a distinct part thereof, including an intermediate nursing facility, which:

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

Specialty/Injectable Drugs

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

Splints

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

Stroke

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

Sub-Acute Facility

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

Substance Use Disorder

Substance Use Disorder is defined as a condition, as defined in the current Diagnostic and Statistical Manual of Mental Disorders, resulting in the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder. The treatment plan must be recommended by a Physician to be eligible for coverage. All

care must be provided by Providers - such as Hospitals or Residential Treatment Programs for inpatient care, and non-residential programs (including Hospital Centers, Treatment Facilities, Physicians and qualified employees of the centers or facilities) for outpatient care.

Substance Use Disorder Detoxification Services

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

Successor Employer

An OGB-Eligible employer that:

1. Employs a former full-time Employee of Louisiana State University System; a former full time Employee, member, or officer of the House of Representatives of the State of Louisiana, or 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 OFB rules governing inter-agency transfers, however such participation shall be limited to the duration of the Memorandum of Understanding between (i) the State of Louisiana, Office of the Governor, Division of Administration; (ii) the State of Louisiana, Office of the Governor, Division of Administration, Office of Group Benefits; and (iii) the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College.
 - d. Continues to remit, via payroll deduction, the Employee (and spouse and/or eligible Dependent, if applicable) portion of the monthly premium for such coverage;
2. And whose successor OGB participating employer ("Successor Employer") remits to the Louisiana State University System, the required employer portion of the monthly premium for such coverage and executes a Participation and Indemnity Agreement similar to that executed by the House of Representatives of the State of Louisiana, the Louisiana State Senate, and the Legislative Budgetary Control Council, in favor of the Louisiana State University System.

Terminal Illness

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

Transfer Form

The Transfer Form refers to the State of Louisiana Office of Group Benefits and Health Maintenance Organization/HMO 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 list as shown below for the following human organ and bone marrow transplant which are determined to be Medically Necessary, and which are not investigational or experimental in nature. An investigational or experimental procedure is one in which the medical use of a service or supply is still under study and the

service or supply is not yet recognized throughout the Provider's profession in the U.S. as safe and effective for the diagnosis and treatment of the illness or injury. This includes but is not limited to all phases of clinical trials, all treatment protocols based on or similar to those used in clinical trials; drugs approved by the FDA under its Treatment Investigational New Drug regulation.

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

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

Urgent Care Center

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

End of Document
LSU System Health Plan
Summary Plan Description
Effective July 1, 2010 – June 30, 2011