

**INSURANCE COMMITTEE OF THE ASSESSORS' INSURANCE FUND
dba LOUISIANA ASSESSORS' ASSOCIATION
EMPLOYEE BENEFIT PLAN**

**Plan Document and Summary Plan
Description** Effective: January 1, 2018

**Third Party Administrator:
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SECTION I DEFINITIONS

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

Note: There may be other terms defined in specific sections of this Plan that appear just in those sections. Those terms may not be defined in this section.

“Accident”

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

“Accidental Bodily Injury” or “Accidental Injury”

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

“Actively At Work” or “Active Employment”

“Actively At Work” or “Active Employment” shall mean the Employee who has begun and is performing all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another designated location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

“ADA”

“ADA” shall mean the American Dental Association.

“Admission”

“Admission” shall mean the period from entry (Admission) into a Hospital or other covered facility until discharge or release. In counting days of Inpatient care, the date of entry and the date of discharge are counted as the same day.

“Affordable Care Act (ACA)”

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

“AHA”

“AHA” shall mean the American Hospital Association.

“Allowable Expenses”

“Allowable Expenses” shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan’s Allowable Expenses shall in no event exceed the Other Plan’s Allowable Expenses.

When some “Other Plan” provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulance”

“Ambulance” shall mean a specially designed or equipped vehicle used only for transporting the critically ill or Injured to a healthcare facility. The Ambulance service must meet state and local requirements for providing transportation of the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

“Ambulatory Surgical Center”

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

“Appliance”

“Appliance” shall mean a device used to replace missing parts, to provide function or for therapeutic use. The term includes dental prostheses, splints, orthodontic Appliances and obturators.

“Approved Clinical Trial”

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

drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

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

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

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

“Assignment of Benefits”

“Assignment of Benefits” shall mean an arrangement whereby the Participant, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, Copayments and the Coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” and Deductibles, Copayments and the Coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary.

“Birthing Center”

“Birthing Center” shall mean any freestanding health facility, place, professional office or Institution which is not a Hospital or in a Hospital, where births occur in a home like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short term recovery after delivery; provide care under the full time supervision of a Physician and either a registered Nurse (R.N.) or a licensed Nurse midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

“Brand Name” and/or “Brand Name Drug”

“Brand Name” or “Brand Name Drug” shall mean a trade name medication.

“Calendar Year”

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

“Case Manager”

“Case Manager” shall mean the person, who develops, coordinates and implements a plan of care unique to the needs of the Participant. The Case Manager may be (1) made available through the Claims Administrator, or (2) a separate entity with a direct contractual relationship with the Plan.

“Cardiac Care Unit”

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

“CDC”

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

“Child” and/or “Children”

“Child” shall mean the Employee’s eligible Dependent Child or Children, as defined within the Eligibility, Enrollment, and Effective Dates section of this document.

“CHIP”

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

“CHIPRA”

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

“Chiropractic Care”

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

“Claim”

“Claim” shall mean a submission to the Plan for payment made under the Plan in accordance with the Plan requirements.

“Claim Determination Period”

“Claim Determination Period” shall mean each Calendar Year.

“Claims Administrator”

“Claims Administrator” shall mean a third party retained by the Plan Administrator and the Plan Sponsor. The Claims Administrator’s responsibilities typically consist of initially determining the validity of the Claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the contract between the Plan Administrator, Plan Sponsor, and Claims Administrator. The Claims Administrator is The Health Plan.

“Clean Claim”

A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a Claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include Claims under investigation for fraud and abuse or Claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

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

“CMS”

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

“COBRA”

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

“Code”

“Code” shall mean the Internal Revenue Code of 1986, as amended.

“Coinsurance”

“Coinsurance” shall mean the charge a Participant must pay for certain Covered Expenses after any applicable Deductibles and Copayments have been paid and until the Out-of-Pocket Maximum has been reached. Covered Expenses subject to Coinsurance and the amounts are

listed in the applicable Schedule(s) of Benefits. Coinsurance is a percentage of the Covered Services.

“Copayment”

“Copayment” (also referred to as “copay”) shall mean the flat dollar amount for which the Participant is financially responsible, if applicable, and as outlined within the relevant Schedule of Benefits.

“Cosmetic Dentistry”

“Cosmetic Dentistry” shall mean unnecessary dental procedures.

“Cosmetic Surgery”

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

“Cost Sharing Amounts”

“Cost Sharing Amounts” shall mean the portion of the cost of a Covered Expense for a benefit that a Participant is responsible for paying out-of-pocket.

“Covered Expense(s)”

“Covered Expense(s)” means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Participant’s health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the relevant Schedule of Benefits and as determined elsewhere in this document.

“Custodial Care”

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

“Deductible”

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

“Dental Service”

“Dental Service” shall mean a professional Dental Service which is included in the list of Dental Services under the Dental Benefits section and is rendered by a Dentist in the necessary treatment of Accidental Injury, dental Disease or defect. It shall also mean:

1. The scaling and cleaning of teeth by a licensed dental hygienist or dental assistant if performed under the supervision and direction of a Dentist and a charge is made for such service by the Dentist.
2. Laboratory services for preparation of dental restoration and dental Prosthetic devices if the Dentist includes the cost of such services or devices in the charges for these services.

“Dentist”

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

“Dependent”

“Dependent” shall mean one or more of the person(s) as defined within the Eligibility, Enrollment, and Effective Date section.

“Diagnosis”

“Diagnosis” shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

“Diagnostic Service”

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

“Disease”

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

“Drug”

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

“Durable Medical Equipment”

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

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

“Educational”

“Educational” shall mean the primary purpose of a service or supply is to provide the Participant with any of the following: training in the activities of daily living, instructions in scholastic skills such as reading and writing, preparation for an occupation or treatment for learning disabilities.

“Elective Surgery”

“Elective Surgery” shall mean a surgical procedure that can be scheduled in advance; that is, it is not an Emergency or of a life threatening nature.

“Emergency”

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

“Emergency Medical Condition”

“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the

Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Services”

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

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

“Employee”

“Employee” shall mean a person who is an active full time Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an Employer-Employee relationship. Such person must be scheduled to work at least 30 hours in order to be considered “full time.”). A retired Employee shall be considered an Employee where appropriate in this Plan.

“Employer”

“Employer” is Insurance Committee of the Assessors’ Insurance Fund dba Louisiana Assessors’ Association and any subsidiary or affiliated entities recognized by the Employer as eligible to participate and that agree to participate in this Plan.

“Endodontics”

“Endodontics” shall mean the branch of Dentistry concerned with the treatment of teeth having damaged pulp; root canal therapy.

“Essential Health Benefits”

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

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term

is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

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

A Drug, device, or medical treatment or procedure is Experimental:

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

Reliable evidence shall mean:

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

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

the following as being Medically Necessary for the specific treatment for which it has been prescribed:

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

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

“Family Unit”

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

“FDA”

“FDA” shall mean Food and Drug Administration.

“FMLA”

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

“FMLA Leave”

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

“Formulary”

“Formulary” shall mean a list of prescription medications of safe, effective therapeutic Drugs specifically covered by this Plan.

“Generic Drug”

“Generic Drug” shall mean a prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

“GINA”

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

“Habilitation/Habilitative Services”

“Habilitation/Habilitative Services” shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and

occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

“Harmful Habit Appliances”

“Harmful Habit Appliances” shall mean appliances to correct tongue thrusting and thumb sucking.

“HIPAA”

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

“Home Health Care”

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

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

“Home Health Care Agency”

“Home Health Care Agency” shall mean an agency or organization which provides a program of Home Health Care and which:

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

“Hospice Agency”

“Hospice Agency” shall mean an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

“Hospice Care Program”

“Hospice Care Program” shall mean a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

“Hospice Care Services and Supplies”

“Hospice Care Services and Supplies” shall mean those provided through a Hospice Agency and under a Hospice Care Program and include Inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

“Hospice Unit”

“Hospice Unit” shall mean a facility or separate Hospital Unit that provides treatment under a Hospice Care Program and admits at least two unrelated persons who are expected to die within six months.

“Hospital”

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

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

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

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

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

1. A facility operating legally as a Rehabilitation Facility for rehabilitative care.
2. A facility operating legally as a Psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
3. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full time facilities for bed care and full time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24 hour a day nursing service by a registered Nurse (R.N.); has a full time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

“HRSA”

“HRSA” shall mean Health Resources and Services Administration.

“Identification (ID) Card”

“Identification (ID) Card” shall mean an Identification Card issued in the covered Employee’s name identifying the membership number of the covered Employee.

“Illness”

“Illness” shall have the meaning set forth in the definition of “Disease.”

“Impregnation and Infertility Treatment”

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

“Incurred”

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

“Injury”

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

“Inpatient”

“Inpatient” shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its Outpatient department, where a Room and Board is charged by the Hospital.

“Institution”

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

“Intensive Care Unit”

“Intensive Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “Cardiac Care Unit”, "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two

beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

“Late Enrollee”

“Late Enrollee” shall mean a Participant who enrolls under the Plan other than during the first thirty (30) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

“Leave of Absence”

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

“Legal Separation”

“Legal Separation” shall mean an arrangement to remain married but live apart, following a court order.

“Mastectomy”

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

“Maximum Amount” or “Maximum Allowable Charge”

“Maximum Amount” and/or “Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed the following:

1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. The negotiated rate established in a contractual arrangement with a Provider;
4. The Reasonable charge specified under the terms of the Plan; or
5. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

“Medically Necessary”

“Medical Care Necessity”, “Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician or Dentist exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that

Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. It must not be primarily custodial in nature;
3. The Plan reserves the right to incorporate the Centers for Medicare and Medicaid Services (CMS) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the Food and Drug Administration (FDA);
2. The prescribed Drug use is supported by one of the following standard reference sources:
 - a. Micromedex[®] DRUGDEX[®];
 - b. The American Hospital Formulary Service Drug Information;
 - c. Medicare approved Compendia; or
 - d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and
3. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

“Medical Record Review”

“Medical Record Review” is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

“Medicare”

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

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

“The Mental Health Parity Provisions” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

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

“Mental or Nervous Disorder”

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

“Morbid Obesity”

“Morbid Obesity” shall mean a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Participant.

“Network”

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

“No-Fault Auto Insurance”

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

“Non-Network”

“Non-Network” shall mean healthcare Providers that are not Network.

“Nurse”

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

“Orthodontics” or “Orthodontia Services”

“Orthodontics” or “Orthodontia Services” shall mean the branch of Dentistry concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in the relationship to the jaws. Commonly, straightening teeth.

“Orthotic”

“Orthotic” shall mean a custom made brace or external device made for a weak, Diseased or injured body part. An Orthotic can increase, decrease or eliminate motion or support the weak, Diseased or injured body part.

“Other Plan”

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

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Federal government plans or programs. This includes, but is not limited to, Medicare and TRICARE;
5. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
6. Any policy of insurance from any insurance company or guarantor of a responsible party;
7. Any policy of insurance from any insurance company or guarantor of a third party;
8. Workers’ compensation or other liability insurance company; or
9. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Out-of-Pocket Maximum”

“Out-of-Pocket Maximum” shall mean the annual aggregate amount for which a Participant will be financially responsible for during the Calendar Year. If applicable, the Out-of-Pocket Maximums are listed in the applicable Schedule of Benefits.

“Outpatient”

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

“Palliative”

“Palliative” shall mean an alleviating measure. To relieve.

“Participant”

“Participant” shall mean any Employee or Dependent or retiree who is eligible for benefits under the Plan.

“Patient Protection and Affordable Care Act (PPACA)”

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

“Per Period of Confinement”

“Per Period of Confinement” shall mean all periods of Hospital Confinements for the same or related cause or causes unless separated by one month during with the Covered Individual was not confined in either a Hospital or Skilled Nursing Facility.

“Periodontics”

“Periodontics” shall mean the science of examination, Diagnosis and treatment of Diseases affecting the Periodontium.

“Periodontium”

“Periodontium” shall mean collectively the tissues which surround and support the tooth: the gingiva, the cementum, the periodontal membrane, and the alveolar or supporting bone.

“Pharmacy Benefit Manager”

“Pharmacy Benefit Manager” shall mean the prescription Drug vendor contracted by the Employer to provide benefits for prescription Drugs.

“Physician”

“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife (C.N.M.), Licensed Clinical Professional Counselor (L.C.P.C.), Licensed

Professional Clinical Counselor (L.P.C.C.), Licensed Professional Counselor (L.P.C.), Midwife, Nurse Practitioner (N.P.), Occupational Therapist, Optometrist (O.D.), Physician Assistant (P.A.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Registered Physical Therapist, Registered Respiratory Therapist, Social Workers (S.W., M.S.W., L.C.S.W., A.C.S.W.), Speech Language Pathologist. In addition, the above Providers must be licensed and regulated by a state or federal agency and must be acting within the scope of his or her license.

“Plan Year”

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

“Post-service Claim”

“Post-service Claim” shall mean a Claim for benefits from the Plan after the medical services and/or supplies have already been provided.

“Precertification”

“Precertification” shall mean authorization from this Plan for specific Covered Expenses in accordance with the Care Management Programs section. Requesting Precertification is a Pre-Service Claim as described in the Claims Procedures; Payment of Claims section.

“Pregnancy”

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

“Preventive Care”

“Preventive Care” shall mean certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act’s (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

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

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

“Primary Care Physician (PCP)”

“Primary Care Physician” shall mean a Family Practitioner, a General Practitioner, an Internist, a Nurse Practitioner, an Obstetrician/Gynecologist, a Pediatrician, a Physician’s Assistant or any provider covered by the Plan who is treating a Mental Disorder or Substance Abuse.

“Prior Plan”

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

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

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Continuation of Coverage applies.

“Privacy Standards”

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

“Prosthetic”

“Prosthetic” shall mean a fixed or removable device that replaces all or part of an extremity or body part, including such devices as an artificial limb, intraocular lens or breast prosthesis.

“Provider”

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

“Psychiatric Hospital”

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

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

“Reasonable”

“Reasonable” and/or “Reasonableness” shall mean in the Plan Administrator’s discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider’s error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Centers for Medicare and Medicaid Services (CMS) and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.

The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

“Rehabilitation Hospital” or “Rehabilitation Facility”

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

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

“Room and Board”

“Room and Board” shall mean a Hospital’s charge for:

1. Room and complete linen service;

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

“Security Standards”

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

“Service Waiting Period”

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

“Sickness”

“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Skilled Nursing Facility”

“Skilled Nursing Facility” shall mean a facility that fully meets all of these tests:

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

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, Rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

“Substance Abuse”

“Substance Abuse” shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use

of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of “Substance Use Disorder” is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more, of the following, occurring within a 12-month period:
 - a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
 - b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 - c. Craving or a strong desire or urge to use a substance; or
 - d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

“Substance Abuse Treatment Center”

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

“Substance Dependence”

“Substance Dependence” shall mean substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the Drug is needed to achieve the same effect); and (4) withdrawal symptoms.

“Surgery”

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

“Surgical Procedure”

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

“Temporomandibular Joint (TMJ) Syndrome”

“Temporomandibular Joint (TMJ) Syndrome” shall mean the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

“Total Disability”

“Total Disability” shall mean the Employee is unable, as a result of Illness or Injury, to perform the normal duties of his occupation and is not performing work of any kind for wage or profit.

“Totally Disabled”

“Totally Disabled” shall have the same meaning set forth in the definition of “Total Disability.”

“Uniformed Services”

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

“USERRA”

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

“Usual and Customary”

“Usual and Customary” (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Usual and Customary does not apply to Network Claims.

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

SECTION II INTRODUCTION

Introduction and Purpose

The Plan Sponsor has established the Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association Employee Benefit Plan (the "Plan") for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. The Plan is amended and restated in its entirety effective January 1, 2018.

Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor, and self-funded with contributions from Participants and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately. As a self-insured health plan, the Plan intends to meet the requirements under Sections 105(b), 105(h) and 106 of the Code so the portion of the cost for coverage paid by the Employer may not be taxable income to the Participant and any benefits received through this Plan may not be taxable income to the Participants. The Plan is not insured.

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

The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association** and may be reviewed at any time during normal working hours by any Participant and by viewing on the website www.healthplan.org.

Note: Words and phrases appearing in initial capital letters are defined terms. The complete definitions can be found in the Definitions section that appears at the end of the document.

Claims Administrator

The Health Plan is the Claims Administrator and will process Claims and answer benefit and Claim questions. The Health Plan will be referred to as the Claims Administrator throughout this document.

The Claims Administrator's customer service representatives are available to answer any questions or concerns regarding this Plan.

The Health Plan
1110 Main Street
Wheeling, WV 26003
Phone: 1-800-624-6961

Plan Document and Summary Plan Description

This document serves as both the written Plan Document, and the Summary Plan Description (SPD). It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under this Plan. The document should be read in its entirety because many of its provisions are interrelated.

Identification (ID) Card

The Identification Card issued to a Participant pursuant to this Plan is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Plan and misuse of such Identification Card may be grounds for termination of a Participant's coverage under this Plan. To be eligible for services or benefits under this Plan, the holder of the Identification Card must be a Participant and must present the Identification Card to the Provider. Any person receiving services or benefits which he is not entitled to receive pursuant to the provisions of this Plan will be charged for such services or benefits at prevailing rates. If any Participant permits the use of his Identification Card by any other person, such card may be retained by this Plan, and all rights of such Participant pursuant to this Plan may be terminated.

Network Providers

If a Participant receives a service that results in an expense, he is responsible for following Plan requirements to maximize his level of coverage. In addition, the Participant is financially responsible for any portion of the expense that is not "covered" under this Plan. Taking care of that responsibility is between a Participant and the Network Provider. Under this Plan, Participants may receive different levels of benefits depending on where Covered Expenses are received and depending upon whether Precertification, if required, was obtained. Generally, when care is received at a Network Provider, the Participant will receive the highest level of benefits at the lowest cost. When care is received from a Non-Network Provider, generally there will be a lower level of coverage and the Participant will also be responsible for any charges above the Usual and Customary and Reasonable charge. In addition, benefits for certain Covered Expenses may be reduced if the Participant does not receive Precertification (if applicable) for the specific Covered Expense. See the Care Management Programs section for a list of services that require Precertification and details on how to obtain Precertification.

The Plan reserves the option to negotiate Network Claims below the stated savings in any preferred Network Provider organization agreement. Any such negotiation and subsequent savings must be used for the benefit of the Plan in its entirety and may be used by the Plan to pay benefits and defray reasonable administrative expenses of the Plan.

Non-Grandfathered Status

This Plan is NOT a “Grandfathered Health Plan” under the Affordable Care Act (the ACA). Questions regarding the Plan’s status can be directed to the Plan Administrator, Louisiana Assessors Association Insurance Fund. The Participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

SECTION III SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

Failure to comply with Care Management will result in a higher cost to Participants. “Care Management” includes Hospital pre-admission certification, continued stay review, length of stay determination, discharge planning and any other programs described within the Care Management Programs section. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan.

Network and Non-Network Provider Arrangement

This Plan recognizes multiple categories of Providers, based on the Provider’s relationship with this Plan:

- Network
- Non-Network
- Out-of-Area

Please refer to the relevant Schedule of Benefits on the following pages for detailed information on coverage levels for Network and Non-Network and Out-of-Area Providers under this Plan.

The benefit percentage paid under this Plan for Network Providers is usually greater than for Non-Network Providers. Because these Network Providers have agreed to charge reduced fees to Participants under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Participant uses a Network Provider, the Participant will generally have a higher payment percentage paid by the Plan than when a Non-Network Provider is used. It is the Participant’s choice as to which Provider to use.

In addition to applicable Deductibles, Copayments and Coinsurance when Non-Network Providers are used, the Participant may have substantial additional costs for which they are responsible because the Plan pays Non-Network Providers based on the Maximum Allowable Charge. In addition to Cost Sharing Amounts, the Participant will also be responsible for any charges above the Maximum Allowable Charge when receiving Covered Expenses at a Non-Network Provider. Therefore, the percentage of payment actually paid by this Plan may be lower than the stated percentage, and the percentage of payment paid by the Participant may be higher than the stated percentage.

The Plan contracts with the Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the Provider Networks are called “Network Providers.” Those who have not contracted with the Networks are

referred to in this Plan as “Non-Network Providers.” This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant receives care from a Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
 - Professional services of an Emergency room Physician, radiologist, pathologist or anesthesiologist when services are rendered in a Network facility.
2. If the charge billed by a Non-Network Provider for any Covered Expense is higher than the Usual and Customary fees or Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts Assignment of Benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.
3. To receive benefit consideration, Participants (or when applicable, Providers on behalf of Participants) must submit Claims for services provided by Non-Network Providers to the Claims Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit Claims themselves.
4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Additional information, including a list of Network Providers, will be provided to Participants, at no cost, and updated as needed. Because the Network Providers are continuously being updated, a current list of Network Providers is available, without charge, through the Claims Administrator’s website.

Enrolling in this Plan does not guarantee that a particular Network Provider will remain a Network Provider or that a particular Provider will provide Participants under this Plan only with Covered Expenses. Participants should verify a Provider’s status as a Network Provider each time services are received from the Provider.

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

Network Provider Information

This Plan contains provisions under which a Participant may receive greater benefits by using certain Providers. These Providers are individuals and entities that have contracted with the Plan to provide services to Participants at pre-negotiated rates. The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Network Provider.

A current list of Network Providers is available, without charge, through the Claims Administrator's website. If the Employee does not have access to a computer at their home, the Employee may access this website at their place of employment. If the Employee has any questions about how to do this, contact Louisiana Assessors Association. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. The Participant should refer to the Identification Card for the Network website address.

Choice of Providers

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

The Plan will not have any liability for any acts, omissions, or conduct of any Provider. The Plan's only obligation is to make payments according to the terms of this Plan Document.

Out-of-Area Plan

If an Out-of-Network provider is utilized, benefits will be payable as stated in the Medical Schedule of Benefits for Out-of-Area providers under the following circumstances:

- Treatment of a Medical Emergency.
- Services not available by an In-Network provider or at an In-Network facility.
- A Participant is outside of the In-Network servicing area. The servicing area is defined as the area within a 30-mile radius of the Participant's primary residence.

The Plan bases payment on the Usual and Customary Charges. In addition to Cost Sharing Amounts, the Participant will also be responsible for any charge above the Usual and Customary Charge.

Each Participant has free choice of any Healthcare Provider, and the Physician-patient relationship shall be maintained. The Participant, together with his Physician, is ultimately

responsible for determining the appropriate course of medical and dental treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Plan will not have any liability for any acts, omissions, or conduct of any provider. The Plan's only obligation is to make payments according to the terms of this Plan Document.

Balance Billing

A Claim submitted by a Network or Non-Network Provider may be subject to a medical bill review or medical chart audit and as a result some or all of the charges may be repriced due to billing errors and/or overcharges. It is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit. Further, it's the Plan's position that the Participant should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Non-Network Providers that engage in balance billing practices.

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

The Participant is responsible for payment of applicable Coinsurances, Deductibles, and Out-of-Pocket Maximums and may be billed for any or all of these.

Cost Sharing Amounts

This section discusses the portion of the cost of a Covered Expense for a benefit that a Participant is responsible for paying out-of-pocket. The Cost Sharing Amount is the dollar amount a Participant is responsible for paying when Covered Expenses are received from a Provider. Cost Sharing Amounts include Coinsurance, Copayment, and Deductible amounts. Cost Sharing Amounts are identified in the applicable Schedule of Benefits. Providers may bill a Participant directly or request payment of Cost Sharing Amounts at the time Covered Expenses are provided.

Coinsurance

The charge a Participant must pay for certain Covered Expenses after any applicable Deductibles and Copayments have been paid and until the Out-of-Pocket Maximum has been reached. Covered Expenses subject to Coinsurance and the amounts are listed in the applicable Schedule of Benefits. Coinsurance is a percentage of the Covered Expenses. In some instances, the Participant will be responsible at the time and place of service to pay any Coinsurance directly to the Provider. In other instances, the Participant will be billed by the Provider. These arrangements are between the Participant and the Provider.

Copayment

In general, Copayment (also referred to as “copay”) refers to the flat dollar, per occurrence amount for which the Participant is financially responsible. The Copayment is the amount a Participant must pay each time certain Covered Expenses are provided, as outlined in the applicable Schedule of Benefits. In some instances, the Participant will be responsible at the time and place of service to pay any Copayment directly to the Provider. In other instances, the Participant will be billed by the Provider. These arrangements are between the Participant and the Provider. Copayments do not apply towards satisfaction of the Deductible but will apply towards satisfaction of the Out-of-Pocket Maximum. In addition, Copayments will continue to apply after the Deductible has been met but will no longer apply once the Out-of-Pocket Maximum has been met.

Deductible

In general, Deductible refers to the annual aggregate amount of Covered Expenses for which the Participant is financially responsible before the Plan has a financial responsibility. The Deductible is the amount of Covered Expenses which must be paid by the Participant or the covered family before benefits are payable. The applicable Schedule of Benefits shows the amount of the appropriate Deductible amount (if any) and the benefits to which it applies.

Copayments do not apply towards satisfaction of the Deductible and Copayments continue to apply after the Deductible has been met.

Each Calendar Year, a new Deductible must be satisfied.

If two or more covered family members are injured in the same Accident, those injured will be required to satisfy only one individual Deductible between them for Covered Expenses related to the same Accident for each Calendar Year that such Accident-related expenses are Incurred.

With respect to satisfying the Network, Non-Network, and Out-of-Area Deductible, amounts applied to the Network Calendar Year Deductible will also count towards the satisfaction of the Out-of-Area Calendar Year Deductible, and vice versa. However, amounts applied to the Non-Network Calendar Year Deductible will not count towards the satisfaction of the Network and Out-of-Area Calendar Year Deductible, and vice versa.

Out-of-Pocket Maximum

In general, the Out-of-Pocket Maximum is the annual aggregate amount for which a Participant will be financially responsible.

The Out-of-Pocket Maximum includes:

- Copayments
- Deductibles
- Coinsurance
- Prescription Copayments

The Out-of-Pocket Maximums are listed in the applicable Schedule of Benefits. When the Out-of-Pocket Maximum is met, this Plan will pay 100% percent of the Covered Expenses for certain Covered Expenses Incurred during the remainder of the Calendar Year.

The Out-of-Pocket Maximum renews on January 1st of each consecutive Calendar Year.

The following amounts are not considered or taken into account with respect to the Out-of-Pocket Maximum:

- Charges that are not Covered Expenses under this Plan (e.g., charges which exceed Usual and Customary amounts and costs paid by the Participant as a result of the Participant's failure to comply with Precertification requirements)
- Charges in excess of applicable Plan maximums.

With respect to satisfying the Network, Non-Network and Out-of-Area Out-of-Pocket Maximum, amounts paid by the Participant to the Network Out-of-Pocket Maximum will also count towards the Out-of-Area Out-of-Pocket Maximum, and vice versa. However, amounts paid by the Participant to the Out-of-Network Out-of-Pocket will not count towards fulfillment of any Out-of-Pocket Maximum.

Amounts in Excess of the Maximum Allowable Charge

This Plan pays no more than the Maximum Allowable Charge for a Covered Expense. However, Usual and Customary limitations will not apply to Network repriced Claims. If the Provider charges more than the Maximum Allowable Charge, the Participant is responsible for the amount in excess of the Maximum Allowable Charge. This excess amount is considered outside the scope of the Plan and is not counted towards satisfaction of the Deductible or the Out-of-Pocket Maximum and is not paid by the Plan upon satisfaction of the Deductible or the Out-of-Pocket Maximum.

Schedule of Benefits

The applicable Schedule of Benefits provides a snapshot of the terms and conditions of the available benefits under this Plan. It is not intended to be comprehensive. Details regarding each of these items are in the later text.

The Covered Expenses for certain services may be reduced or entirely excluded if the Participant does not receive Precertification for the specific Covered Expense. Precertification is always the Participant's responsibility. See the Care Management Programs section appearing later in this document for a list of services that require Precertification and details on how to obtain Precertification.

MEDICAL SCHEDULE OF BENEFITS		
PLAN MAXIMUMS AND LIMITATIONS		
<i>Benefits under the Medical Plan will be available for those Participants who have elected, and are eligible for, this coverage.</i>		
Lifetime Benefit	Unlimited	
Calendar Year Benefit	Unlimited	
Skilled Nursing Facility	60 days per Calendar Year	
Bereavement Counseling (<i>all family members combined</i>)	\$200 per Calendar Year	
Wigs (<i>following chemotherapy</i>)	1 every 3 years	
Preventive Care	Refer to Section III – Medical Benefits	
CALENDAR YEAR DEDUCTIBLE	In-Network	Out-of-Network
Individual	\$500	\$500
Family	3 deductibles	3 deductibles
<i>The Calendar Year Deductible applies to all expenses unless otherwise indicated.</i>		
<i>Amounts applied to the Network Calendar Year Deductible will also apply to the Out-of-Area Calendar Year Deductible, and vice versa. However, the Non-Network Calendar Year Deductible will not apply to the Network and Out-of-Area Calendar Deductible, and vice versa.</i>		
OUT-OF-POCKET MAXIMUM	In-Network	Out-of-Network
Individual	\$2,500	\$5,000
Family	\$12,700	Unlimited
<i>The Out-of-Pocket Maximum includes Deductibles, Coinsurance, and copays) including copays for prescription Drugs covered under the Plan's prescription Drug program). Refer to the Prescription Drug Program's Schedule of Benefits.</i>		
<i>Amounts applied to the Network Out-of-Pocket Maximum will also apply to the Out-of-Area Out-of-Pocket Maximum and vice versa. However, expenses which are incurred from Out-of-Network providers will not apply towards fulfillment of any Out-of-Pocket Maximum</i>		

BENEFIT PERCENTAGES	In-Network	Out-of-Network	Limits
Inpatient Hospital Expenses	\$100 per day copay (1); 10%*	\$100 per day copay (1); 40%*	
Inpatient Physician Expenses	10%*	40%*	
Outpatient Hospital Expenses <i>(facility and professional fees)</i>			
Outpatient Surgery	\$200 copay; 10%*(2)	40%*	
All Other Outpatient Services	10%*	40%*	
Emergency Room Expenses <i>(facility and professional fees)</i>			Copay waived if admitted
Emergency Use	\$100 copay/10%*	\$100 copay/10%*	
Non-Emergency Use	\$100 copay/10%*	\$100 copay/10%*	
Urgent Care	\$45 copay	40%*	
Ambulance Expenses	10%*	40%*	
Skilled Nursing Facility Expenses	10%*	40%*	
Birthing Center Expenses	10%*	40%*	
Hospice Care Expenses	10%*	40%*	
Home Health Care Expenses	10%*	40%*	
Outpatient Private Duty Nursing Expenses	10%*	40%*	
Physician Office Visit Expenses			
Office Visits and Psychotherapy			
PCP	\$30 copay; 0% (2)	40%*	
Specialist	\$45 copay; 0% (2)	40%*	
Office Surgery	\$200 copay; 10%*(2)	40%*	
All Other Office Services	10%*	40%*	
Second Surgical Opinion Expenses	0% (2)	0% (2)	
Chiropractic Care Expenses	10%*	40%*	
<p><i>(1) There is a maximum of 3 copays per Period of Confinement.</i></p> <p><i>(2) The Calendar Year Deductible is waived.</i></p> <p><i>*Until the Out-of-Pocket Maximum has been reached, then covered expenses are payable at 100% for the remainder of that Calendar Year.</i></p>			

BENEFIT PERCENTAGES	In-Network	Out-of-Network	Limits
Outpatient Occupational, Physical and Speech Therapy Expenses	10%*	40%*	
Infertility Treatment	10%*	40%*	
Independent Diagnostic, X-ray and Lab Expenses	10%*	40%*	
Durable Medical Equipment and Supply Expenses			
Insulin Infusion Pumps (<i>including corresponding supplies</i>)	0% (3)	40%*	
All Other Expenses	10%*	40%*	
Preventive Care Services			
Routing Colonoscopies	0% (2)	40%*	
All Other Routine Services	0% (2)	40%*	
All Other Covered Expenses	10%*	40%*	
<p>(2) <i>The Calendar Year Deductible is waived.</i></p> <p>(3) <i>Benefit will be payable at 100% and the Calendar year Deductible will not apply for expenses related to insulin infusion pumps and the corresponding supplies (not available through the Pharmacy Benefits Manager). This benefit is available to Participants who are enrolled in the Disease management Diabetes Incentive Program, and complete the minimum program requirements.</i></p> <p><i>*Until the Out-of-Pocket Maximum has been reached, then covered expenses are payable at 100% for the remainder of that Calendar Year></i></p>			

PRESCRIPTION DRUG BENEFIT	
Calendar Year Deductible	\$100 per Participant <i>(waived for Generic medications)</i>
Retail Benefit – Provided by a Pharmacy Benefit Manager	
Per prescription copay <i>(34-day supply)</i>	\$5 Generic \$25 formulary Brand Name \$40 non-formulary Brand Name \$40 specialty drug <i>(including self-injectables)</i> \$0 diabetic medications and most diabetic supplies
Per prescription copay <i>(34 – 90 day supply)</i>	\$12.50 Generic \$62.50 formulary Brand Name \$112 non-formulary Brand Name \$112 specialty drug <i>(including self-injectables)</i> \$0 diabetic medications and most diabetic supplies ⁽⁴⁾
Mail Order Benefit - Provided by a Pharmacy Benefit Manager	
Per prescription copay <i>(90-day supply)</i>	\$12.50 Generic \$62.50 formulary Brand Name \$112 non-formulary Brand Name \$112 specialty drug <i>(including self-injectables)</i> \$0 diabetic medications and most diabetic supplies ⁽⁴⁾
<p><i>Specialty medications must be purchased through the Special Pharmacy Benefit Program. See the Medical Benefit section.</i></p> <p><i>(4) Copays and Calendar Year Deductibles are waived for Participants who are enrolled in the Disease Management Diabetes Incentive Program, and complete the minimum program requirements, as described in the Medical Benefit section.</i></p> <p><i>The Participant's Deductible, Coinsurance, and copays listed above will apply to the Medical Plan's Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met, covered prescriptions will be reimbursed at 100% for the remainder of the Calendar Year.</i></p>	

DENTAL SCHEDULE OF BENEFITS

Benefits under the Dental Plan will be available for those Participants who have elected, and are eligible for, this coverage.

BENEFIT	
Dental	\$2,000 per Calendar Year <i>(not applicable to Participants under age 19)</i>
Orthodontia	\$2,000 lifetime
DENTAL DEDUCTIBLE	
Individual	\$50
Family	3 deductibles
BENEFIT PERCENTAGES	
Preventive Services	100% <i>(deductible waived)</i>
Basis Services	80%
Major Services	50%
Orthodontia	60%

SECTION IV MEDICAL BENEFITS

Medical Benefits

Medical benefits are available under this Plan when Covered Expenses are Incurred by a Participant for care while the person is covered for these benefits under the Plan. This section is intended to be read in conjunction with the Summary of Benefits section.

Some Covered Expenses are subject to Precertification requirements, as indicated in the Care Management Programs section. Please refer to the Care Management Programs section for information regarding Precertification.

Covered Expenses are those Incurred for the following items of services and supplies when (1) Medically Necessary to diagnose or treat a Participant, or (2) specifically for Preventive Care. These charges are subject to the benefit limits, exclusions and other provisions of this Plan.

Abortion

Induced termination of a Pregnancy by any acceptable means when the life of the mother would be endangered by the continuance of the Pregnancy.

Allergy Treatment

Charges for allergy treatment; including injections, testing and serum.

Ambulance Service

Professional ambulance service to and from the Hospital. In the event that an Illness or Injury requires specialized emergency treatment not available at a local Hospital, transportation for such treatment is covered when ordered by a Physician. The covered transportation is only from the city or town where the disability occurred to the nearest Hospital qualified to render special treatment.

Ambulatory Surgical Center

Facility charges for procedures performed in an Ambulatory Surgical Center and associated services and supplies.

Anesthesia

Services of a qualified anesthesiologist (not the services of an operating surgeon or a surgical assistant) in administering regional or general anesthesia in connection with an eligible Covered Expense. Usual related care rendered in connection with the administration of anesthesia is covered.

Birthing Centers

Facility charges for procedures performed in a Birthing Center and associated services and supplies.

Blood and Plasma

Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

Cardiac Rehabilitation Services

Cardiac rehabilitation services as determined to be Medically Necessary, provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) and provided in an appropriate medical care facility as covered under the terms of the Plan.

Chemotherapy

A regimen comprised of a single agent or a combination of anti-cancer agents clinically recognized for treatment of a specific type of cancer, including modifications and combinations appropriate to the history of the cancer or according to protocol specifying the combination of Drugs, doses, and schedules for administration of the Drugs.

Drug Requirements:

- Use that is included as an indication on the Drug's label as approved by the Food and Drug Administration (FDA).
- Use of an Food and Drug Administration (FDA)-approved Drug for an off-label purpose that is medically accepted for an anti-cancer therapeutic regimen as evidenced by major Drug compendia, medical literature, and/or accepted standards of medical practice.
- Use of Drugs to treat toxicities or side effects of the cancer treatment regimen when the Drug is administered in relation to chemotherapy, including off-label uses supported by medical literature.

Chiropractic Treatment

Examinations, diagnostic evaluations, and treatments by manipulation and other modalities.

Contraceptives

Services and supplies related to contraceptive injectables, implants and intrauterine devices (IUDs) including any fee incurred by a Physician for administration or insertion will be eligible under this Plan.

Note: Certain Covered Expenses are provided under the Preventive Care benefit as described in this Medical Benefit section.

Dental Care for Accidental Injury

Treatment of Accidental Injuries to the jaw, mouth, or sound natural tooth (a tooth which is free of decay but may be restored by fillings, has a live root, and does not have a cap or crown).

Diabetic Services

A Participant actively participating in the Disease Management Program may enroll in the voluntary Disease Management Diabetes Incentive Program. When a Participant completes the minimum requirements of the program, diabetic medication and most diabetic supplies will be provided with \$0 copay and the Deductible will be waived when purchasing the medication or supplies from a participating pharmacy. For any diabetic supply not covered by the Pharmacy Benefit Manager, coverage may be provided under this Medical Plan as described in the Medical Schedule of Benefits.

The minimum requirements of the Diabetic Incentive Program are as follows:

- Disease Management assessment with a The Health Plan Disease Management nurse (once a month);
- Annual foot exam (repeat once a year);
- Annual eye exam, if recommended by a participating Physician, or Physician waiver (repeat once a year);
- Annual laboratory work-up of fasting blood lipid levels (repeat once a year);
- Annual laboratory work-up of urine/protein levels (repeat once a year);
- Laboratory work-up of hemoglobin A1C levels every 6 months (repeat every 6 months).

The Participant will be required to provide documentation to The Health Plan from his Healthcare Provider(s) that the above requirements have been completed.

Diagnostic Services

Services performed for the express purpose of determining the cause of definite symptoms experienced by the patient, not in connection with routine physical examinations except as specified in this Plan. Covered Expenses include:

- Pathology.
- Radiology.
- Physician's Interpretation.

Durable Medical Equipment

Coverage includes, but is not limited to, the following:

Rental or initial purchase (whichever is less expensive, subject to approval by the Plan) of Durable Medical Equipment, including but not limited to respiration equipment, Hospital beds, and wheelchairs. Replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item or the existing equipment is damaged and cannot be made serviceable.

The Plan does not pay for the rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment.”

Emergency Room Services and Supplies

- **Life-Threatening/Sudden & Serious Illness:** Immediate care required for a life-threatening medical Emergency or Accidental Bodily Injury which untreated could result in death or serious bodily impairment.
- **Non-Emergency Use:** Care received for Illness or Injury which does not qualify as life-threatening.

Forensic Medical Exams

Services provided in connection with a forensic medical exam. Benefits will be provided without any Deductible, Copayment or Coinsurance. The Plan will be responsible to submit a claim to the Crime Victims Reparations Fund. This applies to any victim of a sexually oriented criminal offense that occurred on or after January 13, 2015 in compliance with La. R.S. 40:1300.41.

Home Health Care Services and Supplies

Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required.

- **Services:** Part-time or intermittent nursing care provided or supervised by a Registered Nurse (R.N.); part-time or intermittent home health aide services, primarily for the patient’s medical care; physical, occupational, speech, or respiratory therapy by a licensed qualified therapist; nutrition counseling provided by or under the supervision of a registered dietician; or medical supplies, laboratory services, Drugs, and medications prescribed by a Physician.
- **Requirements:** Services must be provided in the patient’s home under a written plan of the patient’s attending Physician’s stating the Diagnosis, certifying that the Home Health Care is in lieu of Hospital confinement or Skilled Nursing Facility care, and further specifying the type and extent of treatment. In addition, Home Health Care must begin within 7 days after a Hospital Confinement.

Hospice Care Services and Supplies

- **Services**
 - Hospice Room and Board while the terminally ill person (diagnosed by the attending Physician as having six months or less to live) is an Inpatient in a hospice.
 - Outpatient and other customary hospice services provided by a hospice or hospice team.
 - Counseling services provided by a member of the hospice team.
- **Requirements:** These services and supplies are eligible only if the hospice operates as an integral part of a Hospice Agency and the hospice team includes at least a doctor and a registered graduate Nurse. Each service or supply must be:
 - Provided under a Hospice Agency program that meets standards set by the Plan. If such a program is required by federal or state law to be licensed, certified, or registered, it must meet that requirement.
 - Provided while the terminally ill person is in a Hospice Care Program.
 - Ordered by the doctor directing the Hospice Care Program.
 - Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered under this Plan). Bereavement services must be furnished within six (6) months after the patient's death. In addition, benefits are limited to the maximum stated in the Medical Schedule of Benefits.

Hospital Inpatient Services and Supplies

- **Room and Board:** Semi-private room accommodations, including general nursing services. Room charges made by a Hospital having only private rooms will be paid at 90% of average Room and Board rate. Expenses for special care units, including general nursing services. Special care units include Intensive Care Units, Cardiac Care Units, respiratory care units, step down units, emergency care facilities, and other units considered by the Plan to be special care units.

If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as semi-private.

- **Ancillary:** Benefits will be payable for Medically Necessary miscellaneous and ancillary services and supplies furnished during a covered Admission.

Hospital Outpatient Services and Supplies

Services rendered in an Outpatient department of a Hospital, includes, but not limited to, the following:

- Allergy testing.
- Chemotherapy.
- Dialysis.
- Laboratory tests and x-rays.
- Pre-admission testing.
- Radiation therapy.
- Respiratory therapy.
- Surgical services.

Infertility Testing and Treatment

Diagnostic procedures and related expenses (including X-ray and laboratory examinations) performed solely to determine the cause of infertility. All treatment of infertility with the exception of prescription medication will also be covered.

Injectable Drugs

Injectable Drugs, unless purchased through the Plan's prescription Drug program. If the injectable Drug is purchased through the Plan's prescription Drug program, any fee Incurred by a Physician for administration will be eligible under this Plan.

Medical Supplies

Coverage includes, but is not limited to, the following:

- Heart pacemaker; surgical dressings; casts; splints; trusses; braces; crutches.
- Oxygen and related supplies.
- Initial contact lenses or glasses required following cataract Surgery.
- Insulin and diabetic supplies (including glucose home monitors for insulin dependent diabetics) unless covered under the Plan's prescription Drug program.

Mental Disorders

- **Inpatient:** Semi-private room accommodations and Medically Necessary services and supplies furnished by the Hospital or facility for Diagnosis or treatment of Mental Disorders. This includes Medically Necessary treatment for services provided when a Participant is admitted and detained in a Hospital or a facility that provides treatment under an emergency certificate issued in accordance with La. R.S. 28:53(P).
- **Outpatient:** Medical expenses for Outpatient treatment of Mental or Nervous Disorders includes, but is not limited to, the following:

- Medically Necessary services and supplies provided by a Hospital or other duly licensed facility on an Outpatient basis, including laboratory testing.
- Physician office visits or Physician visits on an Outpatient basis at a Hospital or other licensed facility.
- Outpatient shock therapy.

Morbid Obesity Treatment

Medically Necessary treatment of Morbid Obesity with concurrent treatment of a serious Illness. For the purposes of this provision, Morbid Obesity is defined as being 100% or 100 pounds over a Participant's ideal body weight.

Newborn Care Services and Supplies

Medically Necessary expenses Incurred by a newborn infant during his initial Hospital confinement. Benefits include services and supplies furnished by the Hospital and Physician. Inpatient Physician care for a healthy, full-term newborn includes, but is not limited to, examinations and the circumcision of male infants.

Covered Expenses for a well newborn Child Incurred for Hospital and Physician services while the mother is confined for delivery and will be added to the Covered Expenses of the mother to determine allowable benefits payable (one Deductible/one Copayment, as applicable).

Covered Expenses for a sick newborn Child Incurred for Hospital and Physician services after birth will be made on the same basis as any other Sickness. Benefits will be payable as expenses of the Child.

Covered Expenses for both well or sick newborn Children will be payable as indicated above, provided the Employee has properly enrolled the Dependents for Dependent benefits within 30 days as specified in the Eligibility, Enrollment and Effective Dates section of this Plan.

Nutritional Counseling

Nutritional counseling rendered by a licensed nutritionist (if licensing is required by the state) or registered dietician. Benefits will be limited to the following conditions: diabetes, pre and post covered weight loss Surgery, and post-cardiac Surgery.

Occupational Therapy

Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting, or at a facility, Institution, or Outpatient facility whose primary purpose is to provide medical care to restore the loss or impairment of motor functions resulting from Illness or Injury. Coverage ends once maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered.

Oral Surgery

Benefits are limited to the following procedures:

- Excision of impacted teeth.
- Excision of tumors or cysts from the mouth.
- Cutting procedures on the gums and mouth tissues for treatment of Disease.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures).
- Treatment of fractures of facial bones.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands or ducts.

Organ Transplants

- **Services:** Covered Services related to non-experimental human organ transplants which are Medically Necessary. Covered procedures Include:
 - Bone Marrow.
 - Cornea.
 - Heart.
 - Heart/lung.
 - Kidney.
 - Liver.
 - Lung.
 - Pancreas.

The Plan will also cover any other types of human organ transplants that become accepted as non-experimental procedures, as determined by the Plan Administrator. Covered Charges include acquisition cost and drugs, even if not otherwise covered under this Plan.

Covered transplant-related expenses incurred by a living donor, provided the recipient is covered under the Plan. Benefits are subject to coordination with any other medical benefits covering the donor.

- **Requirements:** Transplants: Any human solid organ or bone marrow/stem cell transplant provided that:
 - The condition is life-threatening; and
 - Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
 - The patient is a suitable candidate for the transplant.

Orthoptics and/or Visual Training

Physical Therapy

Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed Outpatient therapy facility. Coverage ends once maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered.

Physician Services

Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, and clinic care.

Preadmission Testing

Pregnancy Expenses

Expenses attributable to a Pregnancy.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

Regular Plan benefits (as specified in the applicable sections of this document) are payable for expenses Incurred by the covered Employee, spouse or Dependent Child.

Services required for the normal management of Pregnancy, including any condition usually associated with the management of a difficult Pregnancy but not considered a complication of Pregnancy. Antepartum and postpartum care of the mother is included.

Services required for the treatment of complication of Pregnancy, including any physical effect directly caused by Pregnancy but considered to be an effect of a normal Pregnancy, conditions related to ectopic Pregnancy or conditions requiring cesarean section.

Care for miscarriage.

Note: Certain Covered Expenses may be provided under the Preventive Care benefit as described in this Medical Benefit section.

Prescription Drugs

Prescription benefits are provided outside the medical/surgical benefits of the Plan.

- **Retail:** The Employer has selected a Pharmacy Benefit Manager to provide benefits for prescription Drugs. If a Participant incurs expenses for prescription Drugs, after the Calendar Year prescription Deductible, the prescription Drug plan will pay 100% of the cost of the prescription minus the per prescription copay shown in the Medical Schedule of Benefits.

If a prescription is filled at a participating pharmacy, the Participant will have to pay only the copay amount. The pharmacy will submit the claim to the prescription drug plan, which will reimburse the pharmacy.

If a prescription is filled at a nonparticipating pharmacy, the Participant will have to pay the entire cost of the prescription. For reimbursement, a prescription drug claim form must be completed by the Participant and submitted to the prescription drug plan for reimbursement.

- **Mail Order Benefit:** The Employer has selected a Pharmacy Benefit Manager to provide benefits for mail order drugs. If a Participant incurs expenses for prescription Drugs, after the Calendar Year prescription Deductible, the prescription Drug plan will pay 100% of the cost of the prescription minus the per prescription copay.

This program is particularly beneficial for those individuals who take regular medication over an extended period of time (maintenance medication). Maintenance medication is usually associated with the treatment of such illnesses as anemia, arthritis, diabetes, emotional distress, epilepsy, heart disorders, high blood pressure, thyroid or adrenal conditions, ulcers, etc.

To participate in the mail order drug program, the Participant must send the original prescription, along with the appropriate per prescription copay amount, to the mail order drug service. The medication will then be mailed by the mail order drug service along with reordering instructions.

- **Specialty Drug Benefit:** The Employer has selected a Pharmacy Benefit Manager to provide benefits for specialty medications. Specialty medications must be purchased through the Specialty Pharmacy Benefit Program. The prescription Drug plan will pay 100% of the cost of the specialty medication minus the per prescription copay.

The following conditions may require Drugs that fall under the Specialty Pharmacy Provider Network, if covered, and may include, but are not limited to: cystic fibrosis, multiple sclerosis, hemophilia, rheumatoid arthritis, and viral hepatitis. Prescriptions for

these types of Drugs may be filled only after enrolling in the Specialty Pharmacy Program. Participants must enroll in the Specialty Programs.

Preventive Care

- **Adult and Children Ages 2 and Over:** Routine physical examinations, diagnostic procedures, immunizations, flu shots, pneumonia and shingles vaccines. In addition, the following age and/or frequency limits apply:
 - Physical exams and associated diagnostic procedures – 1 per 12 months
 - Gynecological exams – 1 per 12 months
 - Mammograms – 1 per 12 months
 - PSA tests – 1 per 12 months
 - Colonoscopies – 1 per 5 years, age 50 and over*
 - Colon cancer screening – 1 per 5 years, age 50 and over*

*Benefits may be provided for Participants under age 50 if additional risk factors warrant such diagnostic procedures.

- **Children Birth to Age 2:** Routine periodic office visits, diagnostic procedures, immunizations and flu shots.
- **Preventive and Wellness Services for Adults and Children** - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) and Prevention with respect to the individual involved.

With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at:
<https://www.healthcare.gov/preventive-care-benefits/>.

- **Women’s Preventive Services** - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA’s Women’s Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

- Well-woman visits.
- Gestational diabetes screening.
- Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
- Sexually transmitted infection counseling.
- Human Immunodeficiency Virus (HIV) screening and counseling.
- Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
- Breastfeeding support, supplies and counseling.
- Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:

<http://www.hrsa.gov/womensguidelines/> or at <https://www.healthcare.gov/preventive-care-benefits/>

Note: This Plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA), as amended by the Reconciliation Act and related regulatory guidance. To the extent required by PPACA and the regulatory guidance, the Plan will provide benefits for all healthcare services and supplies rendered solely for the purpose of health maintenance and not for the treatment of an Illness or Injury without any cost-sharing (such as Copayments, Coinsurance or Deductibles). Cost-sharing is permissible for services received from Non-Network Providers. However, if the Plan does not have a Network Provider that can provide a particular Preventive Care service, the Plan will cover the Preventive Care services without cost-sharing if performed by a Non-Network Provider.

Private Duty Nursing

Services certified as Medically Necessary by a Physician and provided by a nurse. The nursing services provided must require the special skill and training of a Registered Nurse or Licensed Practical Nurse.

Prosthetics and Orthotics

Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes (unless attached to a brace) and other supportive devices for the feet.

Radiation Therapy

Radiation therapy by x-ray, radon, radium and radioactive isotopes.

Rehabilitation Facility

Facility charges for rehabilitation treatment performed in a Rehabilitation Facility and associated services and supplies.

Respiration Therapy

Respiration therapy services, when rendered in accordance with a Physician's written treatment plan.

Routine Patient Costs for Participation in an Approved Clinical Trial

Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

- The clinical trial is approved by:
 - The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
 - The National Institute of Health;
 - The U.S. Food and Drug Administration;
 - The U.S. Department of Defense;
 - The U.S. Department of Veterans Affairs; or
 - An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
- The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

- The cost of an Investigational new Drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a Drug or device that is the subject of the Approved Clinical Trial;
- The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
- A cost associated with managing an Approved Clinical Trial;
- The cost of a health care service that is specifically excluded by the Plan; or
- Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

Second Surgical Opinions

Benefits will be payable for a second surgical opinion in the event Elective Surgery is recommended by a Physician. The Physician rendering the second surgical opinion must be a board-certified internist, or a board-certified specialist in the appropriate specialty, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

In the event of conflicting opinions, benefits will also be payable under the second surgical opinion provisions for a third opinion when the first and second surgical opinions disagree.

Skilled Nursing Facility

- **Services:** Services and supplies (other than personal items and professional services) provided while the patient is under continuous medical care and requires 24-hour nursing care, and room and board.
- **Requirements:** Confinement must be ordered by the Physician as Medically Necessary for convalescence from the Illness or Injury that caused the Hospital Confinement. Benefits are limited to the maximum stated in the Medical Schedule of Benefits.

The confinement starts within 14 days of a Hospital confinement of three days.

The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the facility.

Speech Therapy

Therapy rendered by a certified speech therapist/pathologist on the recommendation and evaluation of a Physician to restore already established speech loss due to an Illness or Injury or to correct an impairment due to congenital defect for which corrective surgery has been performed.

Sterilization

Procedures to bring about, but not reverse, sterilization, regardless of Medical Necessity.

Note: Certain Covered Expenses may be provided under the Preventive Care benefit as described in this Medical Benefit section.

Substance Abuse

- **Inpatient:** Semi-private room accommodations and Medically Necessary services and supplies furnished by the Hospital or facility for Diagnosis or treatment of Substance Abuse. This includes Medically Necessary treatment for services provided when a Participant is admitted and detained in a Hospital or facility that provides treatment under an emergency certificate issued in accordance with La. R.S. 28:53(P).

- **Outpatient:** Medical expenses for Outpatient treatment of Substance Abuse including the following:
 - Medically Necessary services and supplies provided by a Hospital or other duly licensed facility on an Outpatient basis.
 - Physician office visits or Physician visits on an Outpatient basis at a Hospital or other licensed facility.

Surgery

- **Surgeon:** Charges for multiple Surgical Procedures will be a Covered Expense subject to the following provisions:
 - If bilateral or multiple Surgical Procedures are performed by one surgeon, benefits will be determined based on the Usual and Customary charge that is allowed for the primary procedures. Then a portion of the Usual and Customary charge will be allowed for each additional procedure performed through the same incision, as well as for each additional procedure performed through a separate incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the Diagnosis will be considered “incidental” and no benefits will be provided for such procedures.
 - If multiple unrelated Surgical Procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Usual and Customary charge for each surgeon’s primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Customary charge percentage allowed for that procedure; and
 - If an assistant surgeon is required, the assistant surgeon’s covered charge will not exceed 25% of the surgeon’s Usual and Customary allowance.
- **Cosmetic/Reconstructive Surgery:** Correction of abnormal congenital conditions and reconstructive Surgery performed as a result of Illness or Injury.
- **Reconstructive Surgery Following Mastectomy:** The Federal Women’s Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Participant is being provided this notice to inform the individual about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

- Reconstruction of the breast on which the Mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the individual and their attending Physician.

Temporomandibular Joint Dysfunction

Covered Expenses and supplies recognized as effective and appropriate by the medical or dental profession as necessary to treat TMJ, myofascial pain dysfunction syndromes and other associated disorders.

Wigs

Charges associated with the purchase of a wig for hair loss due to chemotherapy. Benefits are limited to the maximum stated in the Medical Schedule of Benefits.

SECTION V MEDICAL PLAN EXCLUSIONS

The following exclusions apply to this Plan except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Acupuncture.

Administrative Costs. Care, supplies, treatment, and/or services that are solely for and/or applicable to administrative costs of completing Claim forms and for providing records wherever allowed by applicable law and/or regulation.

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

Biofeedback.

Broken Appointments. Care, supplies, treatment, and/or services that are charged solely due to the Participant's having failed to honor an appointment.

Contraceptives. Contraceptives and medications used for contraceptive purposes, except as specified as a Covered Expense under this Plan. Certain forms of contraceptives may be provided under the Plan's prescription Drug program.

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

Custodial Care. Charges for Custodial Care, domiciliary care, rest cures, services that are primarily Educational in nature (except as specified), or any maintenance-type care which is not reasonably expected to improve the patient's condition (except Hospice Care as specified).

Dental Treatment. Any dental treatment or services, except specified services and Medically Necessary Hospital expenses.

Drugs Requiring a Written Prescription. Except those specified, those taken or administered in whole or in part during confinement in a licensed facility or those administered in a Physician's office are not covered by this Plan. They are provided under a separate plan provided by the Employer through a Pharmacy Benefit Manager.

Educational or Vocational Testing. Services for Educational or vocational testing or training, except as specified or diabetes training.

Excess. Care, supplies, treatment, and/or services that are for charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Exercise Programs. Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental. Care, supplies, treatment, and/or services that are Experimental or Investigational.

Eye Care. Glasses, contact lenses, or eye examinations and/or treatment (surgical or nonsurgical) of refractive error for the correction of vision or the fitting of glasses, except as specified.

Family Member. Services, supplies, care or treatment performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law."

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

Foreign Travel. Care, treatment or supplies received outside of the U.S. if travel is for the sole purpose of obtaining medical services.

Functional Therapy. Charges made for functional therapy for learning or vocational disabilities or for speech, hearing and/or occupational therapy, unless specifically covered under another provision of this Plan.

Genetic Testing. Charges relating to genetic testing.

Note: This exclusion does not apply to any service or supply required by the Patient Protection and Affordable Care Act (PPACA), as amended by the Reconciliation Act and related regulatory guidance, to be included as a Covered Expense under the Preventive Care benefit.

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

Government-Operated Facilities.

1. Care, supplies, treatment, and/or services that are furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments; and
2. Care, supplies, treatment, and/or services that can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

Note: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law.

Hair Loss. Care and treatment for hair loss including wigs, cranial prostheses, hair transplants or any Drug that promises hair growth, whether or not prescribed by a Physician, except for wigs for hair loss due to chemotherapy.

Hearing Aids and Exams. Charges for services or supplies in connection with hearing aids or exams for their fitting and/or repair of hearing aids.

Hospital Employees. Professional services billed by a Physician or Nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Hypnotherapy. Services related to hypnosis unless performed in lieu of anesthesia.

Illegal Acts. Services, supplies, care or treatment of an Illness or Injury sustained during the commission, or attempted commission, of an assault or felony; or Injuries sustained while engaging in an illegal occupation. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Illegal Drugs or Medications. Services, supplies, care or treatment to a Participant for illness or Injury resulting from that Participant's voluntary taking of or being under the influence of any controlled substance, Drug, hallucinogen, or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply (a) if the Injury resulted from being the victim of an

act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Incurred by Other Persons. Services, supplies, care or treatment expenses actually Incurred by other persons, except as specified.

Infertility Medications. Any medication prescribed for infertility.

Marital or Pre-Marital Counseling. Care and treatment for marital or pre-marital counseling.

Medical Necessity. Services, supplies, care or treatment that are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Medicare. Care, supplies, treatment, and/or services that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled “Coordination of Benefits” and “Medicare.”

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

No Coverage. Care, supplies, treatment, and/or services that are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

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

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Illness or Injury.

Non-Emergency Hospital Admissions. Care and treatment billed by a Hospital for non-medical Emergency Admissions on a Friday or a Saturday. This does not apply if Surgery is performed within 24 hours of Admission.

Non-Prescription Drugs. Care, supplies, treatment, and/or services that are for Drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and

without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription Drug must be covered under Preventive Care, subject to the Affordable Care Act.

Not Acceptable. Care, supplies, treatment, and/or services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Covered Provider. Care, supplies, treatment, and/or services that are performed by Providers that do not satisfy all the requirements per the Provider definition as contained within this Plan.

Nutritional Supplements. Care, supplies, treatment, and/or services for nutritional supplements, except as specified under Preventive Care.

Obesity. Care and treatment relating to weight loss or dietary control, including the care and treatment of obesity whether or not it is, in any case a part of the treatment plan for another Illness. However, Medically Necessary charges for Morbid Obesity with concurrent treatment of a serious Illness will be covered.

Occupational Injury or Illness. Care and treatment of an Injury or Illness that is occupational—that is, arises from work for wage or profit including self-employment regardless of the availability of workers' compensation coverage. However, any Illness or Injury of an Assessor which occurs as a result of the normal duties of an Assessor will be covered if said Assessor is not covered by Worker's Compensation.

Organ or Tissue Donor. Care, supplies, treatment, and/or services related to the donation of a human organ or tissue, except as specifically provided.

Orthopedic Shoes. Care, supplies, treatment, and/or services for orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Personal Comfort Items. Personal comfort items or other equipment, includes but is not limited to; air conditioners, air purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription Drugs and medicines, and first aid supplies and non-Hospital adjustable beds, whether or not recommended by a Physician.

Physician Phone Calls or Interviews. Charges made by a doctor for phone calls or interviews when the Physician does not see the patient for treatment.

Prior to Coverage. Care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Private Duty Nursing. Private duty nursing performed on an inpatient basis.

Prohibited by Law. Care, supplies, treatment, and/or services that payment under this Plan is prohibited by law.

Provider Error. Care, supplies, treatment, and/or services that are required as a result of unreasonable Provider error.

Replacement Braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional or the age of the brace makes it no longer functional.

Self-Inflicted Injury. Care, supplies, treatment, and/or services that are Incurred due to an intentionally self-inflicted Injury or Illness, not definitively (a) resulting from being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions). This exclusion does not apply if the Injury resulted from an act of domestic violence. Under HIPAA, benefits for injuries generally covered under a plan cannot be excluded merely because they were self-inflicted or were sustained in connection with a suicide or attempted suicide if the injuries resulted from a medical condition such as depression.

Sex Change. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, Surgery and medical or psychiatric treatment.

Smoking Cessation. Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

Note: This exclusion does not apply to any service or supply required by the Patient Protection and Affordable Care Act (PPACA), as amended by the Reconciliation Act and related regulatory guidance, to be included as a Covered Expense under the Preventive Care benefit.

Speech Therapy. Speech therapy for remedial or Educational purposes or for initial development of natural speech. This would apply to Children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy would be considered Educational in nature and not eligible for coverage. Speech therapy would not meet coverage criteria for the following conditions: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental retardation, resonance, stuttering, and voice defects of pitch, loudness, and quality.

Sterilization Reversal. Care and treatment for reversal of surgical sterilization.

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

Travel or Accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for Ambulance charges as defined as a Covered Expense.

Unreasonable. Care, supplies, treatment, and/or services that are not “Reasonable” and are required to treat Illness or Injuries arising from and due to a Provider’s error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vitamins. Charges for vitamins, minerals, non-prescription food and/or food supplements and non-prescription dietary Drugs, except as required by the Patient Protection and Affordable Care Act (PPACA), as amended by the Reconciliation Act and related regulatory guidance.

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

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition.

SECTION VI DENTAL BENEFITS

Dental benefits are available under this Plan when Covered Expenses are Incurred by a Participant for care while the person is covered for these benefits under the Plan. This section is intended to be read in conjunction with the Schedule of Benefits (Dental).

Dental Deductible

The Deductible amount, if any, is the amount each Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth herein, subject to the limitations and exclusions set forth in this section.

The Dental Deductible does not apply to Preventive services.

If in any Calendar Year three family members each shall have incurred sufficient Covered Expenses to satisfy the Deductible specified, the Deductible shall be deemed to be satisfied for all covered family members for the remainder of that Calendar Year.

Extended Dental Benefits

Dentures or Bridges

If a final impression for a denture has been taken, or tooth for a bridge has been prepared, before coverage ceases, charges for the construction and/or insertion of such denture or bridge will be considered as eligible expenses only to the extent that such construction or insertion procedures are performed within 90 days after termination of coverage.

Dental procedures, other than dentures or bridges, will be considered as eligible expenses if such procedures relate to a particular multiple-appointment dental procedure which has commenced before coverage ceased, but only to the extent that such procedures are performed within 90 days after termination of coverage.

Pre-determination of Dental Benefits

If a planned Dental Service or Participant's proposed course of treatment can be reasonably expected to involve dental charges of \$300 or more, a Participant may submit a description of the procedures to be performed and an estimate of the charges to the Plan Administrator or Claims Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Claims Administrator will notify the Employee, and the Dentist or Physician, of the pre determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required

result. **The pre determination is not a guarantee of payment or approval of a benefit. After treatment is received, a Claim must be filed as a post service Claim, which will be subject to all applicable Plan provisions.**

Alternative Dental Procedures

If two or more alternate procedures, services, or courses of treatment may satisfactorily correct a dental condition, the least expensive procedure will be considered for payment. Such determination will be made by the Claims Administrator based upon professionally endorsed standards of dental care.

Incurred Charge

The charge for a service or supply is considered to be Incurred on the date it is furnished except as follows:

- Expenses for fixed bridgework, crowns, inlays or restorations shall be deemed Incurred on the first day of preparation of the tooth or teeth involved provided the person remains continuously covered during the course of treatment or is eligible under the Extended Dental Benefits provision.
- Expenses for full or partial dentures shall be deemed Incurred on the date the final impression is taken provided the person remains continuously covered during the course of treatment or is eligible under the Extended Dental Benefits provision.
- Expenses for relining or rebasing of an existing partial or complete denture shall be deemed Incurred on the first day of preparation of the reline or rebase of such denture provided the person remains continuously covered during the course of treatment.
- Expenses or charges for endodontic services shall be deemed Incurred on the date the specific root canal procedure commenced provided the person remains continuously covered during the course of treatment or is eligible under the Extended Dental Benefits provision.
- Expenses or charges for orthodontic services shall be deemed Incurred on the date the initial active Appliance was installed.

Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the applicable Schedule of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary fees.

Preventive Services

- Initial or periodic oral examinations, but not more than twice during any twelve consecutive months.
- Prophylaxis, including cleaning, routine scaling and polishing, but not more than twice during any twelve consecutive months.
- Fluoride treatments, but not more than once during any twelve consecutive months.
- Palliative emergency treatment and emergency oral examinations.
- Sealants, for Dependents up to age 16, limited to two treatments of unfilled permanent molars.
- Occlusal guards for the treatment of bruxism.
- Dental X-rays as follows:
 - A full mouth or panorex X-rays, but not more than once during any 36 consecutive months;
 - Bitewing X-rays, but not more than twice per twelve consecutive months;
 - Other dental X-rays as deemed necessary.

Basic Services

- Fillings (amalgam, composite, plastic, acrylic and sedative).
- Pin retention.
- Consultations.
- Extractions.
- Endodontics (root canal therapy).
- Repair of crowns, bridges and dentures.
- Recementation of crowns, inlays and/or bridges.
- Denture relining, but not more than once per denture appliance during any twelve consecutive months.
- Denture rebasing, but not more than once per denture appliance during any twelve consecutive months.

- Biopsies of oral tissue.
- Pulp vitality tests.
- Pulp capping.
- Home visits by a Physician when Medically Necessary in order to render a covered Dental Service.
- Oral surgery.
- Space maintainers, for Dependent children up to age 14, but not more than once during any twelve consecutive months.
- Study models.
- Apicoectomy.
- Hemisection.
- General anesthesia administered in connection with a covered oral surgical procedure only if administered by an individual licensed to administer general anesthesia.
- Intravenous sedation in connection with a covered oral surgical procedure.
- Nitrous oxide.
- Injection of antibiotic drugs.
- Occlusal adjustment.
- Tissue conditioning, but not more than once during any twelve consecutive months.
- Periodontics:
 - Occlusal equilibration, when no restoration is involved.
 - Gingivectomy and gingivoplasty.
 - Gingival curettage.
 - Scaling and root planing.
 - Osseous surgery (osteoplasty and ostectomy), including flap entry and closure.

- Surgical periodontic examination.
- Mucogingivoplastic surgery.
- Management of acute periodontal infection and oral lesions.
- Perio-prophylaxis, but not more than two treatments per quadrant during any twelve consecutive months.

Major Services

- Inlays, onlays, gold restorations, crowns, either restorative or as part of a bridge, including precision attachments for dentures.
- Post and cores.
- Denture adjustments.
- Initial dentures, full and partial, and bridges, fixed and removable.
- Replacement of or addition of teeth to an existing removable denture (full or partial) or fixed bridgework as follows:
 - Replacement or addition of teeth is made necessary by the extraction of natural teeth;
 - Replacement is necessary when an immediate temporary denture was inserted shortly following extraction of teeth and cannot be economically modified to the final shape required;
 - The existing denture or bridgework was installed at least five years prior to its replacement and the existing denture or bridgework cannot be made serviceable.

Covered Orthodontia Services

(Available to all Participants)

Installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.

Diagnostic services, including examination, radiographs and all other diagnostic aids used to determine orthodontic needs only once in any five (5) year period, commencing with the date of the initial visit.

SECTION VII DENTAL PLAN EXCLUSIONS

The following exclusions apply to this Plan except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Administrative Costs. For administrative costs of completing Claim forms or reports or for providing dental records.

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

Appliance Replacement. Appliance replacement performed less than five years after a placement or replacement, except as specified.

Broken Appointments. For charges for broken or missed dental appointments.

Cosmetic Dentistry. Dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists.

Denture Adjustments. Denture adjustments during the first six months following denture placement performed by the same or associated Physician who provided or repaired the Appliance.

Education. Charges solely arising from instruction provided regarding oral health and/or diet, including a plaque control program, except to the extent required under the Patient Protection and Affordable Care Act.

Employer Sponsored Services. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustees, or similar person or group.

Excess. Care, supplies, treatment, and/or services that are for charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental or Investigational. Any treatment unless it is both (1) generally accepted by the dental community in the United States, meaning that the clinical efficacy (including the

anticipation of use outweighing harm) of the treatment has been documented in credible published dental literature which demonstrates that the results of the treatment have been measured for a five-year period or other period generally regarded as valid. (2) The treatment, as compared to accepted alternative treatments for that condition, can reasonably be expected to: (a) result in similar or improved survival, health or function, or (b) alleviate symptoms of or stabilize the condition.

Family Member. Services, supplies, care or treatment performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of “blood” or “in law.”

Foreign Travel. Care, treatment or supplies received outside of the U.S. if travel is for the sole purpose of obtaining Dental Services.

Government Coverage. Any treatment or service which is compensated for or furnished by the local, state or federal government (except where required by law).

Harmful Habit Appliances.

Hygiene. For oral hygiene, plaque control programs or dietary instructions.

Illegal Acts. Services, supplies, care or treatment of an Illness or Injury sustained during the commission, or attempted commission, of an assault or felony; or Injuries sustained while engaging in an illegal occupation. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Lost or Stolen Bridges or Dentures. Charges for replacement of bridges or dentures lost, misplaced or stolen.

Medical Treatment. Services, supplies, or treatment covered under the Medical Plan.

Miscellaneous. The Plan does not cover any dental charge, service or supply not provided by a Dentist or Physician unless it is: (1) specifically for non-Experimental services performed at a dental school under the supervision of a Dentist, and only if the school customarily charges patients for its services, or (2) specifically for cleaning, scaling and/or application of fluoride, and is performed by a licensed dental hygienist under the supervision of a Dentist.

Medically Necessary. Services, supplies, care or treatment that are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

No Charge. Care or treatment for which there would not have been a charge if no coverage had been in force.

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

No Listing. Services which are not included in the list of covered Dental Services.

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing dental supervision or treatment which is appropriate care for the Injury or Illness.

Not Acceptable. Care, supplies, treatment, and/or services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Occupational. Care and treatment of an Injury or Illness that is occupational—that is, arises from work for wage or profit including self-employment regardless of the availability of workers' compensation coverage. However, any illness or Injury of an Assessor which occurs as a result of the normal duties of an Assessor will be covered if said Assessor is not covered by Worker's Compensation.

Personal Comfort Items. Personal hygiene, comfort or convenience items.

Personalized Services. Personalizing Dental Service by added restorations to artificial teeth, implant dentures, use of magnets, or similar procedures.

Prohibited by Law. Care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law.

Provider Error. Care, supplies, treatment, and/or services that are required as a result of unreasonable Provider error.

Replacement of Crowns. Replacement of defective or lost crown until five years have elapsed from the date of insertion.

Replacement of Dentures or Bridges. Replacement at any time of dentures or bridges which can be made serviceable.

Self-Inflicted Injury. Care, supplies, treatment, and/or services that are Incurred due to an intentionally self-inflicted Injury or Illness, not definitively (a) resulting from being the victim of

an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions). This exclusion does not apply if the Injury resulted from an act of domestic violence. Under HIPAA, benefits for injuries generally covered under a plan cannot be excluded merely because they were self-inflicted or were sustained in connection with a suicide or attempted suicide if the injuries resulted from a medical condition such as depression.

Services Before Coverage. Charges Incurred for Dental Services which were ordered or started before coverage began, including but not limited to the installation, manufacture or filling of dental restorations (fillings, inlays, crowns, bridgework and dentures) and orthodontic Appliances.

Splinting. Splinting for periodontal purposes and/or other Appliances or restorations whose primary purpose is to stabilize periodontally involved teeth.

Sport Appliances. Expenses related to services or supplies of the type normally intended for sport or home use.

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

Subsequent Orthodontia Treatment. Orthodontia treatment rendered within five years after the completion of a course of orthodontia treatment.

Temporary Crowns.

Temporomandibular Joint Dysfunction Syndrome. Treatment of Temporomandibular Joint Dysfunction Syndrome (including all myofascial pain syndromes and other associated disorders).

Tooth Implants.

Unreasonable. Care, supplies, treatment, and/or services that are not "Reasonable;" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vertical Dimensions. Appliances or restorations necessary to increase vertical dimensions and/or restore the occlusion.

War/Riot. Care, supplies, treatment, and/or services that Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by

a Participant in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition.

SECTION VIII: SUMMARY OF PRESCRIPTION DRUG BENEFITS

Using the Prescription Drug Card

Participants in this Plan will receive an ID card that allows Participants to purchase prescription Drugs through the prescription Drug card program. Participating pharmacies will display the prescription Drug card company logo. If the card is presented to a participating retail pharmacy when buying prescription Drugs covered by the plan or purchase eligible prescription Drugs through the mail order program, the Participant will be charged as shown in the Medical Schedule of Benefits; however, the Participant must first satisfy the prescription Drug Deductible shown in the Medical Schedule of Benefits. The per Participant, per Calendar Year Deductible applicable to medical expenses does not apply to these prescription Drug expenses.

A current list of participating pharmacies is available, without charge, from the Pharmacy Benefit Manager or through the website listed on the ID card. If an Employee does not have access to a computer at his home, he may access this website at his place of employment. If the Employee has any questions about how to do this, he should contact his Employer. If the Participant does not have the ID card when buying eligible prescriptions from a participating pharmacy or if prescription Drugs are purchased from a non-participating pharmacy, he must pay the full price of the prescription Drug and submit a claim form to the prescription Drug card company. These expenses are reimbursable only by the prescription Drug card company. These claim forms may be obtained from Louisiana Assessors Association.

Covered Prescription Drug Card Expenses

Covered prescription Drug card expenses are the Usual and Customary charges for prescription Drugs purchased from a pharmacy participating in the prescription Drug card system. Such Drugs and medicines are eligible for coverage only if they are used to treat an Illness or Injury of a Participant in the Plan and can be obtained from a licensed pharmacist with a written prescription from a Physician. They are limited to the following:

1. Prescription Drugs, including, but not limited to, contraceptives, pre-natal vitamins and vitamins with fluoride;
2. Compound medications of which at least one ingredient is a prescription Drug in a therapeutic amount;
3. Injectable insulin, including insulin syringes and needles, and diabetic supplies, furnished on written prescription of a Physician.

Covered expenses may not exceed a 34-day supply (90-day supply of insulin) when prescription Drugs are purchased from a participating pharmacy, or a 90-day supply when maintenance medications are purchased through the mail order program or the Retail 90 Program. The amount may not be more than the amount normally prescribed by the Physician.

Retail 90 allows a Participant to go to a limited network or local pharmacies and fill a 90-day supply of maintenance medications in lieu of going through the mail order program.

An expense will be considered to be Incurred for purposes of this benefit, at the time the Drug or medication is received from the pharmacist.

Exclusions From Prescription Drug Coverage

The following exclusions apply to this Plan except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Administration. Any charge for the administration or injection of any Drug or medication.

Anorexiant. Anorexiant or any drug or medication used as an appetite suppressant.

Blood. Blood or blood plasma.

Consumed on Site. Any Drug or medication which is consumed or administered at the place where it is dispensed.

Contraceptives. Contraceptives or contraceptive devices of any kind, except oral contraceptives.

Cosmetic Purposes. Drugs used for cosmetic purposes, such as hair growth stimulants or growth hormones; also, Retin-A for a Covered Individual over age 25, unless precertification is obtained from the Pharmacy Benefit Manager.

Devices. Devices of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).

Diagnostic Agents.

Experimental/Investigational. Drugs labeled: "Caution-limited by federal law to investigational use," or experimental drugs even though a charge is made to the Covered Individual.

FDA. Any drug that is not approved by the Food and Drug Administration or that is prescribed for non-FDA-approved uses.

Immunizations. Immunization agents or biological sera.

Impotence. Drugs for erectile dysfunction or organic impotence in excess of 12 units per month or for 30 days, whichever is less.

Infertility. Any Drug or medication related to or used in the treatment of infertility.

Injectables. Injectables and supplies. A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or treatment other than insulin.

Inpatient Medication. Any drug or medication which is to be taken by or administered to the Covered Individual, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.

Medical Exclusion. Any drug or medication otherwise excluded by the Medical Plan.

No Charge. Any drug or medication which may be properly received without charge under any local, state or federal program, including Worker's Compensation.

No Prescription. Any drug or medication lawfully obtainable without a prescription order of a Physician, except insulin.

Refills. Filling or refilling of a prescription in excess of the number prescribed by the Physician, or the filling or refilling of a prescription after one year from the order of the Physician.

Smoking. Smoking deterrents or smoking cessation medications or supplies.

Vitamins. Vitamins except pre-natal vitamins and vitamins with fluoride that require a prescription.

SECTION IX CARE MANAGEMENT PROGRAMS

Note: These programs are not designed to be the practice of medicine or to be a substitute for the medical judgment of the treating Physician.

Introduction

This section describes the care management programs available under this Plan and the Participant's responsibilities under these programs. Care management programs assist the Participant(s) to obtain the maximum benefit coverage under this Plan while optimizing clinical outcomes across a continuum of care.

The care management programs are designed to assist this Plan in:

1. Evaluating Participant's healthcare services to ensure they are Medically Necessary and appropriate;
2. Evaluating alternative levels of care opportunities;
3. Coordinating care needs;
4. Identifying applicable benefit limitations;
5. Identifying high risk Participants for proactive case management and/or disease management programs when applicable.

This Plan uses the methods described in this section to coordinate and review care, and identify Covered Expenses under the Plan.

Medical Necessity Determinations

Participants will receive benefits under this Plan only for Covered Expenses that are determined to be Medically Necessary and not Experimental or Investigational. The fact that a Physician has prescribed, ordered, recommended, or approved a healthcare service, or has informed the Participant of its availability does not in itself make it Medically Necessary. This Plan will make the final determination of whether any service is Medically Necessary or is considered Experimental or Investigational.

How to Obtain Precertification

The Physician, Participant, or someone on the Participant's behalf (e.g., family member) must call the Care Management Organization listed on the Identification (ID) Card to receive Precertification. The following information is needed:

1. The name of the Participant and the relationship to the covered Employee.
2. The name, Employee identification number and address of the covered Employee.

3. The name of the Employer.
4. The name and telephone number of the treating Physician.
5. The name of the facility, proposed date of Admission, and the proposed length of stay when applicable.
6. The proposed medical or surgical services when applicable.

Note: Failure to follow this procedure will reduce reimbursement received from the Plan. See below.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important to have the Participant's Physician call to obtain Precertification in case there is a need to have a longer stay.

Penalty for Not Obtaining Precertification

Each time Precertification is required under this Plan but not obtained in connection with a Covered Service performed by a covered In-Network or Out-of-Network or Out-of-Area Healthcare Provider, eligible charges related to the Covered Services will be reduced as indicated in this Plan Document. The penalty will be paid outside of the Plan. Any such penalty paid by a Participant does not apply to the Deductible or Out-of-Pocket Maximum.

Inpatient Hospital Precertification

Inpatient Hospital Confinement Precertification is one type of care management program designed to help Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

This program consists of the following:

1. Precertification of Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:
 - a. Hospitalization
 - b. Rehabilitation Facility stays (includes long-term acute care admissions)
 - c. Skilled Nursing Facility stays
2. Retrospective review of Medical Necessity of the listed services provided on an emergency basis.
3. Concurrent review, based on the admitting diagnosis, of the listed services requested by the treating Physician;
4. Certification of services and planning for discharge from a Hospital or cessation of medical treatment.

Concurrent review of a course of treatment and discharge planning from a Hospital are types of utilization management programs. The Care Management Organization will monitor the Participant's Hospital stay and coordinate either the scheduled release or an extension of the Hospital stay.

The Care Management Organization should be notified at least one day prior to a non-Emergency Admission. In the event of an Emergency Admission, Precertification must be obtained within 48 hours or as soon as reasonably possible given the facts and circumstances of the Emergency Admission.

The Coinsurance for Medically Necessary Hospital confinement which would normally be payable will be reduced to 60% of the first \$15,000 if admission and length of stay approval is not obtained as specified above. If the Hospital confinement is due to Morbid Obesity, and if the admission and length of stay approval is not obtained, charges will not be covered.

If the confinement extends beyond the approved length of stay, additional days must be authorized by the Care Management Organization. The same requirements and reduction penalties will apply to the additional days.

Case Management

The Plan may, at its sole discretion and when acting on a basis that precludes individual selection, permit alternative benefits that may otherwise not be payable under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's decision to permit the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan. Case Management is a cost management program administered to provide a timely, coordinated referral to alternative care facilities to a Participant who suffers a catastrophic Illness or Injury while covered under this Plan.

The following are examples of diagnoses that might constitute a catastrophic Illness or Injury:

- High Risk Pregnancy
- Neonatal High Risk Infant
- Cerebral Vascular Accident (CVA or Stroke)
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis (ALS)
- Cancers/Tumor Malignancy
- Severe Cardio/Pulmonary Disease
- Leukemia
- Major Head Trauma and Brain Injury Secondary to Illness
- Spinal Cord Injury
- Amputation
- Multiple Fractures
- Severe Burns

- AIDS
- Transplant
- Any claim expected to exceed \$25,000

When the Case Manager is notified of one of the above diagnoses (or any other diagnosis for which Case Management might be appropriate in the Plan's sole discretion), the Case Manager will contact the Participant to discuss current medical treatment and facilitate future medical care. The Case Manager will also consult with the attending Physician to develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified intermittently as the Participant's condition changes, with the mutual agreement of the Case Manager, the patient, and the attending Physician.

All services and supplies authorized by the treatment plan will be considered Covered Services, whether or not they are otherwise covered under the Plan. The benefit level for alternative treatment settings may be the same as the Hospital benefit level, in the absence of the Case Management program. For all other services and supplies, the benefit level will be the same as the benefit for outpatient medical treatment, in the absence of the program.

Any deviation from the treatment plan without the Case Manager's prior approval will negate the treatment plan, and all charges will be subject to the regular provisions of this Plan.

**SECTION X
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE**

Eligibility

Eligible Employee

To be an Eligible Employee, an employee must have met the eligibility requirements for employee coverage (described below).

An employee becomes eligible for coverage following a Waiting Period of 30 consecutive days of employment.

Waiting Period: This is the time between the first day of employment as an Eligible Employee and the first day of coverage under the Plan.

In addition, an Eligible Employee includes the following:

An active full-time employee who is directly employed in the regular business of and compensated for services by the Employer and regularly works 30 or more hours per week; or

A duly elected or appointed Assessor.

Employee shall also mean retired Assessor or retired Employees of the Employer who retire in accordance with the provisions of R.S. 11: 1421.

If such retired Employee does not elect to continue coverage in the 30 days prior to the date he ceases to be an Employee, or declines or drops coverage at any time after retirement, he will not again be eligible to participate in the Plan. Retired Employees are eligible to continue Dependent coverage; however, if Dependent coverage is not continued or elected at the time of retirement, it cannot be continued or elected at a later date.

The Plan Administrator determines status as an Eligible Employee hereunder.

The following persons do not meet the definition of an Eligible Employee:

- Independent contractors;
- Leased employees;
- Part-time and temporary employees; or
- Any person who is on active duty in any military service of any country for longer than two (2) weeks, unless coverage may be extended pursuant to USERRA.

Eligible Dependents

A Dependent is any one of the following persons:

- a. A covered Employee's spouse. The term "spouse" shall mean the person recognized as the covered Employee's lawfully married spouse under the Code and the laws of the state or District of Columbia where the covered Employee's marriage took place, and a resident of the same country in which the covered Employee resides. The Plan Administrator shall require documentation sufficient to prove the existence of a legal marriage.
- b. A covered Employee's Child until the end of the month in which the Child attains age 26.
- c. Any Child of a covered Employee who is an Alternate Recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.
- d. A covered Employee's Child who is already covered under the Plan, who is 26 years of age or older from the date his coverage would otherwise terminate under the Plan and who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age stated above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan.

To be considered an eligible Dependent, a covered Employee's Child must be one of the following:

- A covered Employee's natural Child.
- A covered Employee's stepchild.
- A covered Employee's legally adopted Child.
- A Child placed in the covered Employee's physical custody whom the covered Employee intends to adopt.
- A Child for whom the covered Employee and/or spouse has been named legal guardian.
- An eligible Employee's Child or Children for whom the eligible Employee has a Qualified Medical Child Support Order (QMCSO).

The following persons do not meet the definition of a Dependent:

- Any person covered under this Plan as a covered Employee.
- Any person covered as a Dependent by another covered Employee.
- A legally separated or divorced former spouse of the covered Employee.
- A covered Employee's domestic partner or the covered Employee's domestic partner's Children.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all Cost Sharing Amounts.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

Enrollment

Note: It is the responsibility of the enrolled Employee to notify his or her Employer of any changes in the Dependent's status.

Enrollment Requirements for Eligible Employees.

An eligible Employee must enroll for coverage by completing the Plan's enrollment process, along with authorizing any required contribution via a form or participating in the Employer's online enrollment process.

Enrollment Requirements for Dependents.

If an eligible Employee intends to cover any Dependents, those Dependents must also be affirmatively enrolled at the time of the Employee's enrollment or when a Dependent is acquired by a covered Employee.

Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for him or herself.

Enrollment Requirements for Newborn Children.

A newborn Child of a covered Employee who does not have Dependent coverage or a newborn Child of a covered Employee who already has Dependent coverage must be affirmatively enrolled in this Plan as stated below under Timely Enrollment. If the newborn Child is not enrolled on a timely basis, any expenses related to the birth will not be covered by this Plan. In addition, if the newborn Child is not enrolled within 30 days of birth, any subsequent enrollment will be considered a Late Enrollment as stated below.

Effective Date of Coverage

Effective Date of Eligible Employee Coverage

Coverage for benefits becomes effective on the date the Employee is eligible for coverage provided the Employee has enrolled and authorized any required contribution or within 30 days of the date eligible.

Effective Date of Dependent Coverage

When a covered Employee enrolls his Dependents and authorizes any required contributions for Dependent coverage, Dependent coverage will become effective as follows:

If an eligible Employee has eligible Dependents at the time he enrolls for coverage, then coverage for those Dependents will be effective on the date the eligible Employee's coverage begins.

If a covered Employee does not have eligible Dependents on the effective date of his coverage and later acquires an eligible Dependent(s), and if he enrolls for Dependent coverage within 30 days of the date of acquisition, then coverage for those Dependent(s) will become effective on the date of acquisition.

If a covered Employee does not have eligible Dependents on the effective date of his coverage and later acquires an eligible Dependent(s), and if he enrolls for Dependent coverage within 30 days of the date of acquisition, then coverage for those Dependent(s) will become effective on the date the enrollment process is completed. However, coverage will be retroactive to the date of birth, adoption or placement for adoption if the covered Employee's first eligible Dependent is a newborn, an adopted Child or a Child placed for adoption.

If the covered Employee is already enrolled for Dependent coverage, any newly acquired Dependents must be enrolled within 30 days of acquisition. Coverage will be effective on the date the enrollment process is completed. However, coverage will be retroactive to the date of birth, adoption or placement for adoption if the covered Employee's first eligible Dependent is a newborn, an adopted Child or a Child placed for adoption.

Timely, Open, or Late Enrollment

Timely Enrollment. The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If two Employees (husband and wife) are covered under the Plan and the covered Employee who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Service Waiting Period as long as coverage has been continuous.

Open Enrollment. This Plan has an open enrollment period. "Open enrollment period" means the period of time during the year in which (1) eligible Employees who are not covered under this Plan may elect to begin coverage and (2) covered Employees will be given an opportunity to change their coverage elections. The terms of the open enrollment period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an open enrollment period. Generally, the open enrollment period is held during the month of December. Coverage will be effective on the subsequent January 1.

Late Enrollment. An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join the Plan at any time by completing the enrollment requirements and authorizing any required contributions.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to a resumption of employment or due to a resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the dates a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Service Waiting Period.

Special Enrollment Rights

Federal law provides Special Enrollment rights under some circumstances. If an eligible Employee is declining enrollment for the employee and/or Dependent (including a Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment under these circumstances must be made within 30 days after the other coverage ends (or after the employer completely stops contributions towards the other coverage).

Special Enrollment Periods

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first day of coverage. Thus, the time between the dates a special enrollee first becomes eligible to enroll under the Plan as a Special Enrollee and the first day of coverage under the Plan is not treated as a Service Waiting Period.

1. Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for other coverage meets all of the following conditions:
 - a. The eligible Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - b. If required by the Plan Administrator, the eligible Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - c. The coverage of the eligible Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions were terminated.

- d. The eligible Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above.

Under these circumstances, coverage will begin on the date of enrollment.

2. For purposes of the above rules, a “loss of eligibility” occurs if one of the following occurs:
 - a. The eligible Employee or Dependent has a loss of eligibility due to the other coverage no longer offering benefits to a class of similarly situated individuals (e.g., ceasing to cover part-time employees).
 - b. The eligible Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - c. The eligible Employee or Dependent has a loss of eligibility when the other coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - d. The eligible Employee or Dependent has a loss of eligibility when the other coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Note: Not a Special Enrollment Situation. If the eligible Employee or Dependent lost the other coverage as a result of the individual’s failure to pay premiums or required contributions or for cause (such as making a fraudulent Claim or an intentional misrepresentation of a material fact in connection with the other coverage), that individual does not have a Special Enrollment Right under this Plan.

3. New Dependents Creating a Special Enrollment Right.
 - a. The eligible Employee is a covered Employee under this Plan (or has met the Service Waiting Period applicable to becoming a covered Employee under this Plan and is eligible to be enrolled under this Plan but for failure to enroll during a previous enrollment period), and
 - b. A person becomes a Dependent of that Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the eligible Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the Spouse of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the eligible Employee must enroll under this Special Enrollment Period in order for any eligible Dependent to enroll.

Note: The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment Period, the Dependent and/or employee must request enrollment during this 31 day period.

The coverage for Dependent and/or eligible Employee enrolled in the Special Enrollment Period will be effective:

- in the case of marriage, the date of the marriage;
- in the case of a Dependent's birth, as of the date of birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Medicaid and State Child Health Insurance Programs

An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

An eligible Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

1. The eligible Employee or Dependent covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent terminated due to loss of eligibility for such coverage, and the eligible Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or State Child Health Insurance Program (CHIP) coverage terminated.
2. The eligible Employee or Dependent becomes eligible for assistance with payment of employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the eligible Employee or Dependent requests enrollment in this Plan within 60 days after the date the eligible Employee or Dependent is determined to be eligible for such assistance.

Note: If a Dependent becomes eligible to enroll under this provision and the eligible Employee is not then enrolled, the eligible Employee must enroll in order for the Dependent to enroll.

Coverage will become effective on the date of enrollment.

Qualified Medical Child Support Orders

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

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

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

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

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

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

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

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

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

A National Medical Support Notice shall be deemed a QMCSO if it:

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

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

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

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

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

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
 - a. Whether the Child is covered under the Plan; and

- b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall:

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

Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Genetic Information Nondiscrimination Act (“GINA”)

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

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health

Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

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

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

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

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

**SECTION XI
CONTINUATION OF COVERAGE**

Family Medical Leave Act Qualified Leave of Absence

Coverage during an FMLA Leave of Absence will be administered in accordance with the policies established by the Employer and applicable law, including the following: (1) during an FMLA Leave of Absence, coverage under this Plan shall be maintained on the same terms and conditions as the coverage would have been provided had the covered Employee not taken the FMLA leave, (2) if Plan coverage lapses during the FMLA leave, coverage will be reinstated upon conclusion of the FMLA leave, and (3) coverage shall be reinstated only if the person(s) had coverage under the Plan when the FMLA leave began.

Other Leave of Absence

If an eligible Employee takes an approved Leave of Absence as determined by the Employer, coverage for the Employee and any eligible Dependents may be continued for a maximum of 2 months to run concurrently with the FMLA Leave of Absence. The eligible Employee will be responsible for making any required contributions to the Plan.

Total Disability Extension of Coverage

If an eligible Employee becomes Totally Disabled as determined by the Employer, coverage for the eligible Employee and any eligible Dependents may be continued for a maximum of 12 months to run concurrently with the FMLA extension of coverage. The eligible Employee will be responsible for making any required contributions to the Plan.

Layoff Extension of Coverage

If an eligible Employee is laid off, coverage for the eligible Employee and any eligible Dependents may be continued for a maximum of 2 months. The eligible Employee will be responsible for making any required contributions to the Plan.

Surviving Spouse/Dependent

Any Dependent benefits which are in effect under this Plan at the time of a Covered Employee who is eligible for retirement or a covered retiree's death will be continued after such death while any required contributions are continued. This continuation of coverage for a spouse or Dependent child must be elected within 90 days following the death of the Employee eligible for retirement or the retiree. If this continuation of coverage is not elected, coverage terminates at the end of the 90-day period. The Dependent is responsible for any required contributions both during and after the 90-day period following the covered Employee or retiree's death

Coverage for such surviving Dependent(s) will end on the earliest of the following:

- The end of the period for which any required contributions have been made.
- The date the Spouse is eligible for other coverage or remarries.
- The date a Dependent child ceases to meet the definition of a Dependent.
- The date the Plan terminates.

Dependent benefits may be provided under this Plan to an Employee or retiree's Dependent child, born after the Employee or retiree's death, provided coverage for his other Dependents is being continued under this provision.

Continuation During USERRA

Note: Although USERRA protections look similar to COBRA protections, USERRA rights are separate and independent from COBRA rights.

An eligible Employee may be entitled to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA requires the Employer to offer Employees and their families (spouse and/or Dependent Children) the opportunity to pay for a temporary extension of health coverage (called "USERRA continuation coverage") at group rates where health coverage under Employer-sponsored group health plan(s) would otherwise end because of the Employee's service in the Uniformed Services.

This notice is intended to inform Participants, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe the individual's USERRA continuation coverage rights. For additional information about rights and obligations under the Plan and under federal law, the Participant should contact the Plan Administrator.

Each person covered under the Plan(s) should read this notice carefully.

Service Leave Event. If covered under this Plan, the Employee has the right to elect USERRA continuation coverage for himself, his spouse, and his Dependents if they lose coverage under this Plan due to an absence from employment for service in the Uniformed Services (a "service leave").

Service in the Uniformed Services. Service in the Uniformed Services generally means the voluntary or involuntary performance of duties in the Uniformed Services. The Uniformed Services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. The eligible Employee has 60 days to elect USERRA continuation coverage, measured from the date their absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If USERRA continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have

been lost. If USERRA continuation coverage is not elected within this period, coverage under the Plan ends. However, if no election is made in a situation in which they are not required (in accordance with USERRA) to provide advance notice of their service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), their coverage will be reinstated on a retroactive basis upon his election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Note: An eligible Employee's spouse and Dependent Child(ren) with coverage under the Plan(s) do not have an independent right to elect USERRA continuation coverage. Their coverage may be continued only if the eligible Employee elects USERRA continuation coverage.

Duration. The law requires that an eligible Employee generally be allowed to maintain USERRA continuation coverage for a 24-month period beginning on the date of their absence from employment for the purpose of performing service begins.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding the service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated Employees or Dependent Participants that are not on service leave.

Cost. A person electing USERRA continuation coverage may have to pay all or part of the cost of USERRA continuation coverage. If the eligible Employee performs service in the Uniformed Services for fewer than 31 days, they will pay the same amount for the coverage that they normally pay. If their service exceeds 30 days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage.

Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. The eligible Employee will be given a grace period within which to make the payment. The length of the grace period will be 30 days.

Termination of the Continuation Coverage. The USERRA continuation coverage may be terminated for any of the following reasons:

- The Employer no longer provides group health coverage to any of its Employees;
- The premium for USERRA continuation coverage is not paid on time (including the grace period);
- The Employee's failure to return from service or apply for a position of employment as required under USERRA; or
- Termination for cause under the generally applicable terms of this Plan (e.g., submission of fraudulent benefit Claims).

Insurability. The Employee does not have to demonstrate “insurability” to elect USERRA continuation coverage.

Continuation During COBRA – Introduction

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

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse’s plan), even if that plan generally doesn’t accept Late Enrollees.

A. COBRA Continuation Coverage

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

B. Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee’s Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if they lose their coverage under the Plan because either one of the following Qualifying Events happens:

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

The spouse of a covered Employee will become a Qualified Beneficiary if they lose their coverage under the Plan because any of the following Qualifying Events happens:

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

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

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

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

C. Employer Notice of Qualifying Events

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

D. Employee Notice of Qualifying Events

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

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from their spouse;
2. **Notice of Child's Loss of Dependent Status:** Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. **Notice of a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. **Notice Regarding Disability:** Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage; and
5. **Notice Regarding End of Disability:** Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

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

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

Notification must be received by the COBRA Administrator.

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

E. Deadline for Providing the Notice

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

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

with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

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

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

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

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

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

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

F. Who Can Provide the Notice

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

G. Required Contents of the Notice

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

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

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

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

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

H. Electing COBRA Continuation Coverage

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

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

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

I. Duration of COBRA Continuation Coverage

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

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

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

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus eight months).

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

J. Disability Extension of COBRA Continuation Coverage

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

K. Second Qualifying Event Extension of COBRA Continuation Coverage

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

L. Shorter Duration of COBRA Continuation Coverage

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

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage may conclude prior to the latest possible date if the Employer ceases to provide a group health plan to any Employee; the Qualified Beneficiary fails to make timely payment of any required contributions or premium; the Qualified Beneficiary gains coverage under another group health plan (as an Employee or otherwise) or becomes entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); and/or any other event occurs which enables the Plan Administrator to terminate coverage without offering COBRA Continuation Coverage (such as the commission of fraud by the Qualified Beneficiary and/or their Dependent).

M. Contribution and/or Premium Requirements

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

N. Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 has extended certain provisions of the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her

eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or they have any questions they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: <https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC>.

Additional Information

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

Insurance Committee of the Assessors' Insurance Fund
dba Louisiana Assessors' Association
Plan Administrator
3060 Valley Creek Drive
Baton Rouge, LA 70808
Phone: 225-928-8886

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

Current Addresses

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

SECTION XII
TERMINATION AND REINSTATEMENT OF COVERAGE

Termination Dates of Employee Coverage

The coverage of any Employee under this Plan will terminate on the earliest to occur of the following dates (In certain circumstances, a covered Employee may be eligible for COBRA or USERRA Continuation of Coverage. See Continuation of Coverage section in this document):

1. The date upon which the Plan is terminated.
2. The date that the Employee ceases to be an eligible Employee. This includes death or termination of employment of the Employee.
3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of their failure to make, when due, any contribution for coverage for themselves to which they have agreed in writing.
4. The date of the month in which they are no longer eligible for such coverage under the Plan.
5. The date the Employee elects in writing that termination of coverage occurs.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or their Dependent, or upon the Employee or their Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

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

document.

8. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.
9. Immediately upon submission of a fraudulent Claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or their Dependent, or upon the Employee or their Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Reinstatement of Coverage for COBRA Participants

A qualified beneficiary who has elected COBRA continuation coverage will be considered to have had no lapse of coverage, provided the coverage is in effect on the day before the Employee returns to eligible employment.

Reinstatement of Coverage Following a Military Leave

Special Rules apply to those eligible Employees whose coverage is reinstated following a Leave of Absence governed by the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA). Under USERRA, a Participant entitled to have coverage reinstated upon returning to work following a military Leave of Absence shall be treated as if no break in coverage occurred during the leave. In addition, any Deductible or Out-of-Pocket Maximum satisfied prior to the USERRA leave will be credited if reinstatement takes place during the same Calendar Year in which the expenses were Incurred. For more information regarding USERRA rights, see the Continuation of Coverage section of this document

SECTION XIII COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans including Medicare are paying. When a Participant is covered by this Plan and another plan, or the Employee's Dependent is covered by this Plan and by another plan or the Employee's Dependents are covered under two or more plans, the plans will coordinate benefits when a Claim is received. By coordinating the payment of benefits of those Participants having coverage with one or more group plans, maximum benefit for services may be provided by paying up to but not more than 100% of the Allowable Expenses. In some cases payment will be less than 100%.

Benefits Subject to This Provision

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

Excess Insurance

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

The Plan's benefits will be excess to, whenever possible:

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

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

“Allowable Expenses”

“Allowable Expenses” shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan’s Allowable Expenses shall in no event exceed the Other Plan’s Allowable Expenses.

When some “Other Plan” provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

“Claim Determination Period”

“Claim Determination Period” shall mean each Calendar Year.

Effect on Benefits

A. Application to Benefit Determinations

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

If the Employee’s spouse is eligible for group health coverage through his or her employment, whether as an active employee or a retired employee, and whether or not the spouse has elected coverage under that plan, this Plan will pay benefits as secondary payer for such spouse.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual’s election under personal injury protection (PIP) coverage with the automobile insurance carrier.

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

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

B. Order of Benefit Determination

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

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses Claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom Claim is made is a Dependent Child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. When the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or
 - b. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

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

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

Right to Receive and Release Necessary Information

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

Facility of Payment

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

Right of Recovery

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

Workers' Compensation

Coverage under this Plan is not in lieu of workers' compensation.

SECTION XIV MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

SECTION XV
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).
2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without distribution except for reimbursement to the Plan or the Plan’s assignee. The Plan’s right will continue to apply without regard to coverage status or whether the Participant has terminated coverage under the Plan. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.
3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.
2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Participant(s) fails to file a claim or pursue damages against:
 - a. The responsible party, its insurer, or any other source on behalf of that party.
 - b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
 - c. Any policy of insurance from any insurance company or guarantor of a third party.
 - d. Workers' compensation or other liability insurance company.
 - e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is

fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

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

- b. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
 - c. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
 - d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.
2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.
3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

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

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

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

Separation of Funds

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

Wrongful Death

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

Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
 - b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
 - c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
 - d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
 - e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
 - f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
 - g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
 - h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
 - i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
 - j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.
2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

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

Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

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

Severability

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

SECTION XVI HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses the individual's personal health information. It also describes certain rights the individual has regarding this information. Additional copies of our Notice of Privacy Practices are available by calling 225-928-8886.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS;
and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as permitted or required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a) Privacy Officer: Is an Employee, or class of Employees, or other persons under control of the Plan Sponsor, who shall be given access to the PHI to be disclosed. The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
 - b) In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant’s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant’s information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
 - b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of Food and Drug Administration (FDA)-regulated products or activities;
 - c. Locate and notify persons of recalls of products they may be using; and

- d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes them to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing them would place them at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if they are, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities or armed forces personnel under certain circumstances. As authorized by law, the Plan may

disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as their representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as their personal representative, or treating such person as their personal representative could endanger the Participant; and

2. Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by them who are involved in their care or payment for their care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that they receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;

3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of their PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about them in certain records maintained by the Plan. If the Participant requests copies, they may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of the individual's PHI transmitted directly to another designated person, they should contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend their PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if they do not provide a reason for the request; and
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated their privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file their complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Privacy Compliance Coordinator Contact Information:

Insurance Committee of the Assessors' Insurance Fund
dba Louisiana Assessors' Association
3060 Valley Creek Drive
Baton Rouge, LA 70808
Phone: 225-928-8886

SECTION XVII HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI)**, as defined in section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents**, as defined within section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:
 - a. Written notice by first-class mail to the Participant (or next of kin) at the last known address or, if specified by the Participant, e-mail;
 - b. If the Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a “substitute form”;
 - c. If an urgent notice is required, the Plan may contact the Participant by telephone.

The breach notification will have the following content:

- Brief description of what happened, including date of breach and date discovered;
 - Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
 - Steps the Participant should take to protect from potential harm;
 - What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;
 3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and
 4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

**SECTION XVIII
CLAIM PROCEDURES; PAYMENT OF CLAIMS**

Definitions

“Adverse Benefit Determination”

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

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

“Claimant”

“Claimant” shall mean any plan Participant or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

“Final Internal Adverse Benefit Determination”

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

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

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

Health Claims

Full and final authority to adjudicate Claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make Claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law. To receive due consideration, Claims for benefits and questions regarding said Claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process Claims in accordance with the terms of the Plan and the Plan Administrator’s directive(s). The Claims

Administrator is not a fiduciary of the Plan and does not have discretionary authority to make Claims payment decisions or interpret the meaning of the Plan terms.

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

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

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

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

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

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

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

Urgent care or Emergency medical services or Admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the

Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim, said Claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their Claim(s) as soon as reasonably possible.

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

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

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

A. When Claims Must Be Filed

Post-service health Claims (which must be Clean Claims) must be filed with the Claims Administrator within 12 months of the date charges for the service(s) and/or supplies were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

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

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

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

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

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

B. Timing of Claim Decisions

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

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

2. Pre-service Non-urgent Care Claims:

- a. If the Claimant has provided all of the information needed to process the Claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the Claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
- b. If the Claimant has not provided all of the information needed to process the Claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than five days after receipt of the Claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:

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

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

4. Post-service Claims:

- a. If the Claimant has provided all of the information needed to process the Claim, in a reasonable period of time, but not later than 30 days after receipt of the Claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
 - c. If the Claimant has not provided all of the information needed to process the Claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.
 - i. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care Claims.
 - ii. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
 - iii. Extensions – Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
5. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a Claim is deemed to be filed in accordance with the procedures of the Plan.

C. Notification of an Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

A. Full and Fair Review of All Claims

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

1. At least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. The opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits;
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal Claims and appeals process;
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither

the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claim, even if the Plan did not rely upon their advice;
8. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances; and
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

B. Requirements for Appeal

The Claimant must file an appeal regarding a Post-service Claim and applicable Adverse Benefit Determination, in writing within at least 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service urgent care Claims, if the Claimant chooses to initiate an appeal orally, the Claimant may telephone:

The Health Plan
1110 Main Street
Wheeling, WV 26003
1-800-624-6961

Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

1. For Pre-service Claims:

Claimants should refer to their Identification (ID) Card for the name and address of the Care Management Organization. All Pre-service Claims must be sent to the Care Management Organization.

2. For Post-service Claims:

The Health Plan
1110 Main Street
Wheeling, WV 26003
Phone: 1-800-624-6961

It shall be the responsibility of the Claimant to submit proof that the Claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant;
2. The Employee/Claimant's distinguishing member identification number;
3. The group name or identification number;
4. All facts and theories supporting the Claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

C. Timing of Notification of Benefit Determination on Review

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

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal;
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal;
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of Claim: Pre-service Urgent, Pre-service Non-urgent or Post-service; and
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal. Note, this timeframe is reduced to no later than 30 days per internal appeal should the Plan allow for two levels of internal appeal.

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

D. Manner and Content of Notification of Adverse Benefit Determination on Review

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

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

E. Furnishing Documents in the Event of an Adverse Determination

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

F. Decision on Review

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

G. External Review Process

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

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

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the “expedited external review” paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing

date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
 - c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations;
 - d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate Claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the Claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
 - a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an Admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.
3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the Claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal Claims and appeals process.
4. Notice of final external review decision. The Plan's (or Claims Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

I. Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

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

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

Appointment of Authorized Representative

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

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

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

Recognition as an authorized representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Claimant shall not be recognized as a designation of the

Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Physical Examinations

Should there be, in the Plan Administrator's discretion, any question as to the Claimant's health or physical condition, such that the Medical Necessity of care sought by the Claimant is called into question, the Plan may, at its own expense, have a Physician of its choice perform a physical examination, as necessary to confirm Medical Necessity. Should the Claimant refuse to comply with said exam, the care may be deemed to be excluded by the Plan, at the Plan Administrator's discretion.

Autopsy

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

Payment of Benefits

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

A. Assignments

Assignment by a Claimant to the Provider of the Claimant's right to submit Claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the Provider accepts said Assignment of Benefits as consideration in full for services rendered. If benefits are paid, however, directly to the Claimant – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Claimant's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid; and the Claimant shall retain final authority to revoke such Assignment of Benefits if a Provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Claimant, has been received.

No Claimant shall at any time, either during the time in which he or she is a Claimant in the Plan, or following his or her termination as a Claimant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit Claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

B. Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of Benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If Assignment of Benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the Claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and Claims for benefits must be submitted to the Plan in English.

C. Recovery of Payments

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

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

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

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

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider

error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

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

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

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

D. Medicaid Coverage

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

E. Limitation of Action

Unless there are special circumstances, the appeals process outlined above must be completed prior to initiating legal action regarding a Claim for benefits. If a Claimant intends to initiate legal action, he must do so within two years after receipt of a notification of an Adverse Benefit Determination. If, due to special circumstances, the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two years of the date the Claimant's Claim for benefits was submitted to this Plan. Claimants may not bring legal action after the expiration of the two-year period.

SECTION XIX PLAN ADMINISTRATION

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

Plan Administrator

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

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

Discretionary Authority

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

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

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding

upon all persons claiming any interest under the Plan subject only to the Claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To adopt and implement procedures, including care management recommendations, in its sole discretion;
9. To appoint and supervise a Claims Administrator to pay Claims;
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Plan Administration Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of Plans assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to Participants, and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.

- By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

Named Fiduciary

A "named fiduciary" is the fiduciary named in the Plan. A Named Fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the Named Fiduciary allocates its responsibility to other persons, the Named Fiduciary shall not be liable for any act or omission of such person unless either:

- The Named Fiduciary has violated its stated duties under applicable law in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- The Named Fiduciary breached its fiduciary responsibility under applicable law.

Amending and Terminating the Plan

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

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

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding Claims and all expenses of Plan termination.

Summary of Material Modification (SMM)

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

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its

adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

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

Summary of Material Reduction (SMR)

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

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

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

Misuse of Identification (ID) Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any Identification (ID) Card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated upon the date written notice is given.

SECTION XX PARTICIPANT'S RIGHTS

As a Participant in this Plan, the Employee is entitled to certain rights. All Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of documents, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. (The Plan Administrator may make a reasonable charge for the copies.)

If the Participant has any questions about this statement or about rights under HIPAA, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The Participant may also obtain certain publications about his or her rights and responsibilities under HIPAA by calling the publications hotline of the Employee Benefits Security Administration.

The Participants in this Plan have the sole right to select their own Providers of health care. The Plan will not choose a Provider for any Participant, or have any liability for any acts, omissions, or conduct of any Provider. The Plan's only obligation is to make payments according to the terms of this Plan Document. The payments that the Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

A Participant will have the right to assign the payment of any benefits for which he is eligible under this Plan to any eligible Provider of services. If a Provider makes a representation to the Claims Administrator that a person covered under this Plan has made an Assignment of Benefit payments to the Provider, the Claims Administrator will make payment to the Provider based on that representation.

SECTION XXI GENERAL PROVISIONS

Clerical Error/Delay

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

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

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement. It is intended that the Plan will conform to the requirements of any other applicable law.

Fraud

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

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

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

Headings

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

Word Usage

Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

Titles for Reference

The titles used within this document are for reference purposes only. In the event of a discrepancy between a title and the content of a section, the content of a section shall control.

Misstatements

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 amount.

No Waiver or Estoppel

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

Plan Contributions

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

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

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

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

Release of Medical Information

The Plan Administrator and Claims Administrator are entitled to receive information reasonably necessary to administer this Plan, subject to all applicable confidentiality requirements as defined in this Plan and as required by law, from any healthcare Provider of services to a Participant. By accepting coverage under this Plan, Participants agree to sign the necessary authorization directing any healthcare Provider that has attended or treated them, to release to the Plan Administrator and Claims Administrator upon request, any and all information, records or copies of records relating to attendance, examination or treatment rendered to Participant. If the Participant fails to sign the necessary authorization or otherwise inhibits the Plan Administrator and/or Claims Administrator from getting necessary information to pay Claims, this Plan has no obligation to pay Claims.

Non Discrimination Policy

This Plan will not discriminate against any Participant based on race, color, religion, national origin, disability, gender, sexual preference, or age. This Plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.

This Plan is intended to be nondiscriminatory and to meet the requirements under applicable sections of the Internal Revenue Code of 1986. If the Plan Administrator determines before or during any Plan Year, that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code of 1986 or any limitation on benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated eligible Employees, to assure compliance with such requirements or limitation.

Severability

In the event that any provision of this Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

Written Notice

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

Right of Recovery

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

Statements

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

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

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or

for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Binding Arbitration

Any dispute or Claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any Claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a Claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular Claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or Claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or Claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by a neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

**SECTION XXII
PLAN INFORMATION**

The following information about this Plan is important for Participants to know, and much of it is required to be provided.

Name of Plan:

Insurance Committee of the Assessors' Insurance Fund
dba Louisiana Assessors' Association Employee Benefit Plan

Plan Sponsor:

Insurance Committee of the Assessors' Insurance Fund
dba Louisiana Assessors' Association
3060 Valley Creek Drive
Baton Rouge, LA 70808
Phone: 225-928-8886

Plan Administrator:

(Named Fiduciary)

Insurance Committee of the Assessors' Insurance Fund
dba Louisiana Assessors' Association
3060 Valley Creek Drive
Baton Rouge, LA 70808
Phone: 225-928-8886

Plan Sponsor ID No. (EIN):

72-6014133

Source of Funding:

Self-Funded

Plan Status:

Non-Grandfathered

Applicable Law:

Federal and the State of Louisiana

Plan Year:

January 1st through December 31st

Claims Administrator:

The Health Plan
1110 Main Street
Wheeling, WV 26003

Participating Employer(s):

Insurance Committee of the Assessors' Insurance Fund
dba Louisiana Assessors' Association

Agent for Service of Process:

Insurance Committee of the Assessors' Insurance Fund
dba Louisiana Assessors' Association
3060 Valley Creek Drive
Baton Rouge, LA 70808
Phone: 225-928-8886

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

Legal Entity; Service of Process

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

Not a Contract

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

Mental Health Parity

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

Applicable Law

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. Your rights as a Participant in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be read in such a way so as to conform with any and all applicable law, regulation or court order (if such a court is of competent jurisdiction). Where necessary, the governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations are deemed to be automatically amended to so conform.

Discretionary Authority

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

**ESTABLISHMENT OF THE PLAN;
ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION**

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by the **Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association** (the "Employer" or the "Plan Sponsor") as of January 1, 2018, hereby sets forth the provisions of the Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association Employee Benefit Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

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

Adoption of the Plan Document

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

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

Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association

By: Nannette Menou

Name: NANNETTE MENO

Title: EXECUTIVE DIRECTOR

Date: 1/17/2018