

# **Louisiana State University System**

## **The Definity Health Option Summary Plan Description**

Effective July 1, 2003 – June 30, 2004

## Contents

The Sections of the Summary Plan Description appear in the order set forth below

|  |    |
|--|----|
| <b>DEFINITY HEALTH HIGHLIGHTS</b>                                | 3  |
| <b>HOW THE DEFINITY HEALTH OPTION WORKS</b>                      | 6  |
| Personal Care Account  | 6  |
| Health Coverage Plan   | 10 |
| In-Network Providers   | 16 |
| <b>ELIGIBILITY AND HOW TO ENROLL</b>                             | 18 |
| Who Is Eligible  | 18 |
| How to Enroll  | 19 |
| When Coverage Begins   | 19 |
| Coverage Levels and Eligible Dependents                          | 20 |
| When Your Coverage Ends  | 30 |
| When Your Dependent's Coverage Ends                              | 30 |
| <b>COST</b>  | 33 |
| <b>WHAT'S COVERED UNDER THE DEFINITY HEALTH OPTION</b>           | 34 |
| Preventive Care - Scheduled Benefits                             | 34 |
| Covered Under the Personal Care Account Only                     | 36 |
| Covered Under the Personal Care Account and Health Coverage Plan | 37 |
| Prescription Drug Coverage                                       | 42 |
| Definity Health Personal Care Support                            | 44 |
| Alternative Care Settings  | 47 |
| Other Covered Services   | 49 |
| <b>BENEFIT LIMITS</b>  | 55 |
| Creditable Coverage Under HIPAA                                  | 55 |

|   |           |
|---|-----------|
| Usual and Customary Charges                   | 56        |
| Benefit Maximums                              | 57        |
| Exclusions Under the Health Coverage Plan     | 58        |
| <b>FILING CLAIMS</b>                          | <b>75</b> |
| Coordination of Benefits                      | 77        |
| Right of Recovery                             | 81        |
| <b>CONTINUING YOUR COVERAGE</b>               | <b>84</b> |
| Continuing Coverage During a Leave of Absence | 84        |
| Continuing Your Coverage through COBRA        | 86        |
| <b>OTHER PLAN INFORMATION</b>                 | <b>90</b> |
| <b>DEFINITIONS</b>                            | <b>96</b> |

## Definity Health Highlights

The Definity Health Option allows your Employer to provide you comprehensive health and wellness coverage that gives you a unique way to pay routine health expenses and provides coverage for major healthcare expenses.

### The Definity Health Option

- lets **you** choose your provider (no referrals required)
- allows you to spend or save Benefit Dollars in your Personal Care Account for eligible health expenses
- covers many preventive care services at 100%; see the Preventive Care section of What's Covered under the Definity Health Option
- provides four coverage levels— Employee Only, Employee plus Spouse, Employee plus Child(ren) or Family —so you can pick a coverage level appropriate for you and your family and
- offers the added benefit of a personal care consultant to help you make informed decisions about your family's healthcare purchases (for more information, visit [www.definityhealth.com](http://www.definityhealth.com))

The Definity Health Option is a combination of two separate plans:

- The Health Coverage Plan provides major medical health coverage, except that the Plan Year Deductible (the amount you have to pay) may be higher than you have experienced under other health plans.
- The Health Expense Reimbursement Plan allows your Employer to set up a Personal Care Account (or "PCA") in your name. Your Employer will allocate Benefit Dollars on a Plan Year basis to your PCA for the payment of eligible Covered Expenses. Your PCA is part of the Health Expense Reimbursement Plan, and is not itself a separate plan.

Nor is the "Definity Health Option" itself a separate plan. It is a term used to refer to the two separate plans described above. The Definity Health Option adds value by administering these otherwise separate plans together to help you maximize your health benefits.

Each Plan Year, your Employer will allocate a certain number of “Benefit Dollars” to your Personal Care Account (PCA). Benefit Dollars are not real dollars. You may use Benefit Dollars in your PCA to help pay for the Deductible or other out-of-pocket expenses under the Health Coverage Plan, or you may use them to pay for certain eligible health expenses not covered by the Health Coverage Plan (such as excess over Usual and Customary charges). They will carry forward to the next Plan Year, up to the PCA limit set by your Employer.

If you don’t spend all your Benefit Dollars in a Plan Year, they will carry forward into the next Plan Year up to the PCA limit set by your Employer. In this manner your PCA may “grow” almost like a savings account. But keep in mind that Benefit Dollars under your PCA are subject to two restrictions: first, they may only be used for Covered Expenses as defined in this SPD (see sections entitled “Covered Under the Personal Care Account Only” and “Covered under the Personal Care Account and the Health Coverage Plan” beginning on page 36), and second, you will lose your Benefit Dollars when you are no longer covered under the Definity Health Option or you change the manner in which you participate (i.e., change from employee to dependent). The amount of Benefit Dollars that your Employer allocates to your Personal Care Account each Plan Year depends on the level of coverage you choose. See the section entitled, “Personal Care Account,” or “How the Definity Health Option Works,” for the amount of Benefit Dollars allocated by your Employer.

If you need more expensive medical care, the Health Coverage Plan provides additional protection. Under the Health Coverage Plan, you may see any doctor, specialist or healthcare facility you wish, as long as the benefits you receive are covered under the Plan; however, the Health Coverage Plan will pay a greater percentage of Covered Expenses when Network Providers are utilized. The Health Coverage Plan has a Deductible and an out-of-pocket limit that is based on the Employer’s Plan Year, and pays a percentage of Covered Expenses.

### *Doctor or Physician*

Under the Definity Health Option, "Doctor" or "Physician" means a legally licensed Doctor of:

- 1) Medicine;
- 2) Osteopathy;
- 3) Dentistry;
- 4) Podiatry;
- 5) Chiropractic;
- 6) Optometry;
- 7) or a social worker, physical therapist, occupational therapist, speech therapist or licensed psychologist.

Definity Health is a private healthcare administrator. Our goal is to give you the tools you need to make wise healthcare decisions. We also help your Employer to administer claims. Although we will assist you in many ways, Definity Health is not an insurance company, and does not guarantee any benefits. Your Employer is solely responsible for paying health benefits described in this summary.

Please read this booklet thoroughly to learn how the Definity Health Option works. If you have questions contact your Human Resources Department or call the Definity Health toll-free customer service line at 1.866.DEFINITY (866.333.4648).

## How the Definity Health Option Works

The Definity Health Option consists of two separate plans: 1) the Health Expense Reimbursement Plan and 2) the Health Coverage Plan. Your Personal Care Account will be established under the Health Expense Reimbursement Plan.

### Personal Care Account

Each Plan Year, your Employer allocates a certain amount of Benefit Dollars to a Personal Care Account (PCA) set up in your name, as shown below. Your Employer does not set aside any actual dollars into a fund or account, and claims for benefits from your PCA will be paid from your Employer's general assets. You may use the Benefit Dollars in your PCA to pay eligible healthcare expenses, such as your Deductible, prescription drugs and certain health costs that may not be payable under the Health Coverage Plan. The amount of Benefit Dollars your Employer allocates to your PCA is determined on a Plan Year basis.

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

When you go to the doctor, show your Definity Health ID card and the cost will be deducted from your PCA based on your balance at the time Definity Health processes your claim. You use your PCA to pay for any eligible healthcare expenses, including those not payable under the Health Coverage Plan — such as your Deductible, coinsurance and any Covered Expense listed under the section entitled “Covered Under the Personal Care Account Only.” You do not need to spend your Benefit Dollars for preventive care: those benefits are covered – with no Deductible – through the Health Coverage Plan. (A complete list of Preventive Care Expenses covered under this benefit and any limitations that apply can be found in the section entitled “What’s Covered Under the Definity Health Option, Preventive Care – Scheduled Benefits” at page 34)

In most cases, your eligible expenses are paid through your PCA first. Once you’ve met your Deductible, the Health Coverage Plan kicks in. Keep in mind that expenses paid through the PCA may not also be claimed as a deduction on your tax return or submitted for reimbursement through a flexible spending account.

You can keep track of the Benefit Dollars in your PCA by going online to [www.definityhealth.com](http://www.definityhealth.com), calling the toll-free Definity Health customer service number or checking your quarterly statement.

Any Benefit Dollars left in your PCA at the end of the Plan Year stay in your PCA for your use during the following Plan Year; these are “rollover dollars.” Your PCA, including rollover dollars and new allocations of dollars, may not exceed \$4,000 in a Plan Year.

If you use all the Benefit Dollars in your PCA, you are responsible for meeting the remainder of your Deductible and paying your share of any additional healthcare costs you incur during the Plan Year.

### **How Benefit Dollars are Used**

There are two (2) Plans – the Health Expense Reimbursement Plan, which we call the PCA and the Health Coverage Plan, which provides major medical coverage.

The PCA covers two (2) types of expenses:

- expenses payable under the Health Coverage Plan
- limited classes of expenses not payable under the Health Coverage Plan that are listed on page 36 in the section entitled “Covered Under Personal Account Only”

When the PCA pays expenses payable under the Health Coverage Plan, these reduce the Deductible.

When the PCA pays “PCA only expenses,” the Deductible is not reduced.

“PCA only expenses” will not be paid by the Health Coverage Plan, even after the Deductible is met.

**☞ Important Note: The PCA and Flexible Spending Accounts**

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

- The PCA is only available if you enroll in the Health Coverage Plan—you cannot elect it separately and you can't drop out of it unless you drop out of the Health Coverage Plan as well. Your participation in the flexible spending account is not related to your participation in one or more of your Employer's health programs.
- While the PCA and the flexible spending account may cover some of the same types of expenses, the flexible spending account may be funded with pre-tax contributions under a salary reduction arrangement. You are not permitted to contribute any amount of your income to the PCA.
- Expenses reimbursed through the PCA cannot also be reimbursed through the flexible spending account.

**① For More Information**

For more information about your PCA, visit the Definity Health Web site at [www.definityhealth.com](http://www.definityhealth.com) or call 1.886.DEFINITY (866.333.4648).


## Health Coverage Plan

Under the Health Coverage Plan, you may see any doctor, specialist or healthcare facility you wish. However, the Health Coverage Plan will pay a greater percentage of Covered Expenses when Network Providers are utilized. The Plan has a Deductible which must be met before the Plan pays any benefits. Thereafter, the Plan pays a percentage of Covered Expenses until the out-of-pocket limit is reached. The Deductible and out-of-pocket limit are based on the Employer's Plan Year. After the Deductible and out-of-pocket limits are reached, the Plan will pay Covered Expenses at 100%, subject to certain limitations. The Deductible does not apply to Preventive Care (see Schedule of Benefits); these costs will be covered at 100% In-Network and Out-of-Network subject to some limitations.

### *Deductible*

The Health Coverage Plan requires you and/or your dependent(s) to satisfy a Plan Year Deductible, as set forth in the Schedule of Benefits, before it begins to pay benefits. In many cases, the amount in your PCA will cover a portion of your Deductible. Once your Deductible is met by incurring Covered Expenses, the Plan pays a certain percentage of Covered Expenses until you reach your out-of-pocket limit. See the following section entitled "Coinsurance and Out of Pocket Limits" for more information on these items.

Once you've met your out-of-pocket limit (see Schedule of Benefits, below), the Plan pays 100% of Covered Expenses for the rest of the Plan Year, subject to certain limitations.

 **Important Note:** Many Covered Expenses that are reimbursed through your PCA will count towards your Plan Year Deductible. Expenses covered only under the PCA **will not** count toward your Deductible. For a list of PCA-only expenses, see the sections entitled "Covered Under the Personal Care Account Only," and "What's Covered under the Definity Health Option."

### *Coinsurance and Out-of-Pocket Limits*

Once you have met the Deductible for the Plan Year, the Health Coverage Plan pays the Coinsurance percentage, as shown in the Schedule of Benefits, for in-network charges as well as out-of-network charges, subject to any limits or exclusions shown in the Plan. You pay the remainder until your total Coinsurance payments meet the Plan's out-of-pocket limit for the Plan Year, after which the Plan pays 100% of Covered Expenses for the rest of the Plan Year subject to certain limitations. Please note that expenses paid under the Deductible will not be used to meet the out-of-pocket limit.

Once you reach your out-of-pocket limit for the Plan Year, the Health Coverage Plan pays 100% of in-network charges and 100% of usual and customary ("U&C") out-of-network charges for Covered Expenses for the rest of the Plan Year, subject to any Maximum Individual Lifetime Limit and other limitations. (See section entitled "Benefit Limits," beginning on page 55)

#### **☞ Important Note:**

The out-of-pocket limits are different for in-network and out-of-network charges, and each must be separately met before the Plan begins to pay at 100% of eligible expenses. There is only one exception: If you have met the full out-of-network out-of-pocket limit, you will be considered to have met the full in-network out-of-pocket limit as well.

Expenses are covered differently under the PCA and under the Health Coverage Plan portions of the Definity Health Option. Expenses eligible under the Personal Care Account are covered at 100%, up to the balance in your PCA. Expenses eligible under the Health Coverage Plan are subject to a Deductible, coinsurance and certain other limitations as shown below:

*Schedule of Benefits*

| <u>Plan Year Deductible</u><br>(Includes PCA Amounts) | <u>Employee</u> | <u>Employee<br/>+ Spouse</u> | <u>Employee<br/>+ Child(ren)</u> | <u>Family</u> |
|---|-----------------|------------------------------|----------------------------------|---------------|
| <b>Option 1</b>                                       |                 |                              |                                  |               |
| PCA   | \$1,000         | \$1,500                      | \$1,500                          | \$2,000       |
| Member Responsibility                                 | <u>500</u>      | <u>750</u>                   | <u>750</u>                       | <u>1,000</u>  |
| Total Deductible                                      | \$1,500         | \$2,250                      | \$2,250                          | \$3,000       |
| <b>Option 2</b>                                       |                 |                              |                                  |               |
| PCA   | \$1,000         | \$1,500                      | \$1,500                          | \$2,000       |
| Member Responsibility                                 | <u>1,500</u>    | <u>2,250</u>                 | <u>2,250</u>                     | <u>3,000</u>  |
| Total Deductible                                      | \$2,500         | \$3,750                      | \$3,750                          | \$5,000       |

| <i>Benefit</i>  | <i>In-Network</i>  | <i>Out-of-Network</i>   |                       |         |
|---|--|---|-----------------------|---------|
| Coinsurance   | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible up to U&C  |                       |         |
| Out-of-Pocket Limit<br>(Does not include Deductible)                                | <u>Option 1</u>  |   |                       |         |
|   | Employee   | \$1,000   | Employee              | \$3,000 |
|   | Employee + Spouse  | \$1,500   | Employee + Spouse     | \$4,500 |
|   | Employee + Child(ren)  | \$1,500   | Employee + Child(ren) | \$4,500 |
|   | Family   | \$2,000   | Family                | \$6,000 |
|   | <u>Option 2</u>  |   |                       |         |
|   | Employee   | \$1,000   | Employee              | \$4,000 |
|   | Employee + Spouse  | \$1,500   | Employee + Spouse     | \$6,000 |
|   | Employee+ Child(ren)   | \$1,500   | Employee + Child(ren) | \$6,000 |
|   | Family   | \$2,000   | Family                | \$8,000 |
| Maximum Individual Lifetime Limit<br>(In-Network and Out-of-Network combined)       | \$2,000,000 per person   |   |                       |         |
| Preventive Care Services  | Plan pays 100% of Scheduled Benefits (as listed under Preventive Care section); Deductible and PCA do not apply. Maximum \$350/adult (same as out of network)  | Plan pays 100% of Scheduled Benefits <b>up to U&amp;C</b> (as listed under Preventive Care section); Deductible and PCA do not apply. Maximum \$350/adult (same as in network)  |                       |         |
| Lab & X-Ray   | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible, up to U&C   |                       |         |
| Prescription Drugs  | Plan pays 90% of Covered Expenses after Deductible if you use: <ul style="list-style-type: none"> <li>• a network pharmacy; and</li> <li>• your Definity Health ID card; and</li> <li>• a generic substitution when available</li> </ul> | You pay the cost of the prescription at the pharmacy. The Plan will reimburse you the cost of the prescription as if it had been filled at an in-network pharmacy, subject to applicable deductibles and coinsurance. |                       |         |
| Retail: up to a 90 day supply   |  |   |                       |         |
| Mail Order: up to a 90 day supply<br>(In-Network and Out-of-Network combined)       |  |   |                       |         |
| Your pharmacist or physician may impose additional limits as medically appropriate. |  |   |                       |         |

| <i>Benefit</i>   | <i>In-Network</i>                                      | <i>Out-of-Network</i>  |
|--|--|--|
| Physician Services   | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C            |
| Office Visits  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C            |
| Maternity Care<br>- 48 hour stay for normal vaginal births, 96 hour stay for normal cesarean birth<br>Maternity care for dependent children is not covered   | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C            |
| Inpatient Hospital Care<br>- Semi-private room required  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C            |
| Outpatient Hospital Care   | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C            |
| Emergency Room   | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 90% of Covered Expenses after the Deductible, up to billed charges |
| Urgent Care  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 90% of Covered Expenses after the Deductible, up to U&C            |
| Ambulance <ul style="list-style-type: none"> <li>● Ground transportation licensed to provide basic or advanced life support to the nearest medical facility equipped to treat illness</li> <li>● Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse</li> <li>● Emergency air ambulance</li> </ul> | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 90% of Covered Expenses after the Deductible, up to U&C            |

| <i>Benefit</i>   | <i>In-Network</i>  | <i>Out-of-Network</i>  |
|--|--|--|
| Substance Abuse and Mental Health<br>Inpatient<br>- limited to 45 days per Plan Year. (In-Network and Out-of-Network combined)*<br><br>Outpatient<br>- limited to 52 visits per Plan Year. (In-Network and Out-of-Network combined)* | Plan pays 90% of Covered Expenses after the Deductible<br><br>Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C<br><br>Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| <b>*Please note that in no event will your Mental Health Benefits be reduced by any Substance Abuse benefits received. However, any Mental Health Benefits that you receive will reduce available Substance Abuse benefits.</b>      |  |  |
| Chiropractic Care  | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible, up to U&C  |
| Durable Medical Equipment  | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible, up to U&C  |
| Hospice  | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible, up to U&C  |
| Home Healthcare<br>- limited to 180 visits per Plan Year<br>(In-Network and Out-of-Network combined)<br>- One visit = four consecutive hours in a 24 hour period   | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible, up to U&C  |
| Skilled Nursing Facility<br>- limited to 120 days per Plan Year<br>(In-Network and Out-of-Network combined)  | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible, up to U&C  |
| Transplants<br>- limited to two transplant procedures for the same condition per person subject to Maximum Individual Lifetime Limit   | Plan pays 90% of Covered Expenses after the Deductible   | Plan pays 70% of Covered Expenses after the Deductible, up to U&C  |

| <i>Benefit</i>  | <i>In-Network</i>                                      | <i>Out-of-Network</i>   |
|---|--|---|
| Home Infusion Therapy   | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Medical Supplies  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Physical Therapy<br>- limited to 25 visits per Plan Year  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Speech Therapy<br>- limited to 25 visits per Plan Year  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Occupational Therapy<br>- limited to 25 visits per Plan Year  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Inpatient Rehabilitation<br>- limited to 90 days per Plan Year  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Radiation / Chemo Therapy   | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Accidental Dental Care<br>- Treatment must begin within 90 days of accident to sound, natural teeth and end within 24 months. | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| TMJ   | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |
| Wigs for hair loss due to cancer or alopecia<br>- limited to \$750 per Plan Year  | Plan pays 90% of Covered Expenses after the Deductible | Plan pays 70% of Covered Expenses after the Deductible, up to U&C |

## **In-Network Providers**

When you use an In-Network physician or hospital, you'll save money. In-Network providers have agreed to charge participants in the Definity Health Option a reduced fee. Therefore you can make your PCA go farther by using In-Network providers. In addition, the Health Coverage Plan will pay a greater percentage of Covered Expenses billed by In-Network providers. To determine if a provider is in the network, log onto [www.definityhealth.com](http://www.definityhealth.com) and click under the Find a Provider tab. You may also call 1.866.DEFINITY (866.333.4648) and a customer service representative can locate a provider in the network.

If you require a service that is not available from an In-network provider or facility within 30 miles of your home, you may use an Out-of-Network provider or facility, with the prior approval of Definity Health. Covered Expenses provided by the Out-of-Network provider/facility will be reimbursed at 90% of U & C, subject to the Deductible and other restrictions. Requests for this benefit should be made before services are utilized by calling 1.866.DEFINITY (866.333.4648).

## ***Participating Provider Organization***

The Plan Administrator (or its designated agent) may select a Participating Provider Organization (PPO) to be made available to Participants in a particular geographical area. The PPO's available as of the Effective Date are American LIFECare in Louisiana, Arkansas, and Mississippi and Beech Street Corporation in all other areas. Where a PPO has been selected, Participants in the PPO's service area shall be enrolled in the Plan's PPO Coverage Options. The PPO Coverage Options provide applicable Participants the option of using Participating Providers for their Plan benefits. Participants may choose any qualified provider of medical services or medical supplies for their health care needs.

The applicable Schedule of Benefits specifies the benefit differences when Participating Providers are used. All benefits are subject to all of the other terms of this Plan.

The PPO and Participating Providers are independent contractors. Neither the Plan Administrator nor the Employer make any warranty regarding the services or supplies of Participating Providers or any

other providers of health care services or supplies for which a Participant may obtain reimbursement as a Plan benefit, nor do the Plan Administrator or Employer have any control or influence over any medical care decisions made by health care providers.

⇨ **Key Terms:**

**Covered Expense**

Means the expenses as defined and listed on the sections entitled, “What’s Covered under the Definity Health Option;” “Covered under the Personal Care Account Only;” and “Covered Under the Personal Care Account and the Health Coverage Plan.” See pages 36 and 37.

**Maximum Individual Lifetime Limit**

The Plan will pay benefits limited to the Maximum Individual Lifetime Limit shown in the Schedule of Benefits. This limit applies separately to you and each of your eligible dependents. When benefits paid or payable reach this limit for a covered, all coverage for that covered person will terminate.

**Plan Year**

Plan Year means July 1<sup>st</sup> of each year through June 30<sup>th</sup> of the following year.

## Eligibility and How to Enroll

### Who Is Eligible

You are eligible to participate in the Definity Health Option if you are:

- 1) a full-time employee or a retiree of the Louisiana State University System, or
- 2) a full-time employee, member, officer or retiree of the House of Representatives of the State of Louisiana, or
- 3) a full-time employee, member, officer or retiree of the Louisiana State Senate, or
- 4) eligible spouses and dependents of employees as described the section entitled Coverage Levels and Eligible Dependents

“Full-time employee” means a person employed at 75% effort (30 hours per week), or greater, with an appointment of more than 120 days or one academic semester. Legislative Assistants are eligible to participate in the Plan if they are declared to be full-time employees by their Employer and have at least one year of experience or receive at least 80% of their total compensation as Legislative Assistants.

The terms of the following paragraphs apply to the Health Coverage portion of the Plan.

### *Pre-Existing Condition Exclusion*

Medical expenses incurred during the first 12 months that coverage for the employee and/or dependents is in force under the Plan will **not** be considered as covered medical expenses if they are incurred in connection with a disease, illness, accident or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 month period immediately prior to the effective date of coverage. The provisions of this section do not apply to pregnancy. The Pre-Existing Condition Exclusion does not apply to the PCA, preventive care, or prescription drug coverage. This 12 month exclusionary period may be reduced as described below.

### *Credit for Prior Coverage*

If the covered person was previously covered under a group health plan, Medicare, Medicaid or other “creditable coverage” as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the 12 month exclusionary period will be reduced by the duration of such “creditable coverage,” so long as all such creditable coverage was earned after any “significant break in coverage.”

A significant break in coverage occurs when a person has 63 or more consecutive days with no creditable coverage. When a significant break in coverage occurs, all prior creditable coverage is lost.

Note: You may use PCA dollars to pay for covered expenses subject to the pre-existing condition exclusion. Please refer to the section entitled “What are How Benefit Dollars are Used” on page 8.

### **How to Enroll**

You’ll receive a packet of information including a benefits election form when you begin work. You’ll use the benefits election form to enroll in (or decline) the Definity Health Option and to authorize your Employer to deduct your contributions from your pay. You must sign and return this form to your Human Resources department within 30 days of your date of hire. Also, you must enroll any eligible dependent(s) within 30 days of your date of hire.

### **When Coverage Begins**

Coverage begins on the first of the month following one full calendar month of employment. If you are an employee and are not actively at work on the date coverage would otherwise become effective, coverage will begin when you return to work. If you are not actively at work for a health-related reason, however, this limitation will not apply, and you will be eligible for benefits to the same extent as any other eligible employee.

## Coverage Levels and Eligible Dependents

You can choose from the following coverage levels:

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

Your eligible dependents include:

1. your legal spouse;
2. your never married children from date of birth (must be added to coverage by completing appropriate enrollment documents) up to 21 years of age, dependent upon you for support;
3. your never married children 21 years of age, but less than 24 years of age, who are enrolled and attending classes as full-time students and who depend upon you for support. The term “full-time student” means a student who is enrolled at an accredited college or university, or at a vocational, technical, or vocational-technical or trade school or institute, or secondary school, for the number of hours or courses which is considered to be full-time attendance by the institution the student is attending. It is your responsibility to furnish proof acceptable to Definity Health documenting the full-time student status of a dependent child for each semester.
4. your dependent parent or a dependent parent of your legal spouse, if living in your household, who was enrolled prior to July 1, 1984, and who is, or will be, claimed as a dependent on your federal income tax return in the current tax year. Your Employer will require an affidavit stating you intend to include the parent as a dependent on your federal income tax return for the current tax year. Continuation of coverage will be contingent upon the payment of a separate premium for this coverage.

5. grandchildren for whom you do not have legal custody, who are dependent upon you for support, and one of whose parents is a covered dependent. If you are seeking to cover a grandchild for whom you are a paternal grandparent, your Employer will require that the biological father, i.e. your covered son, to execute an acknowledgement of paternity.

If a dependent parent becomes ineligible for coverage, the grandchild becomes ineligible for coverage, unless you have legal custody of the grandchild.

Children means:

1. your legitimate, duly acknowledged, or legally adopted children;
2. any children in the process of being adopted by you through an agency adoption who are living in your household and who are or will be included as a dependent on your federal income tax return for the current or next tax year (if filing is required);
3. other children for whom you have legal custody, who live in your household, and who are or will be included as dependents on your federal income tax return for the current or next tax year (if filing is required).

### ***Continuing Dependent Coverage Past Age 21***

If a never married dependent child is incapable of self-sustaining employment by reason of mental retardation or physical incapacity and became incapable prior to the termination age for children and is dependent upon the covered employee for support, the coverage for the dependent child may be continued for the duration of incapacity.

1. Prior to attainment of age 21, Definity Health must receive documentation for dependents who are mentally retarded or who have a physical incapacity.
2. For purposes of this section, mental illness does not constitute mental retardation.
3. Definity Health may require that the covered employee submit current proof from a licensed medical doctor of continued mental retardation or physical incapacity as often as it may deem necessary.

### **Surviving Dependents/Spouse**

The provisions of this section apply to surviving dependents who elect to continue coverage following the death of an employee or retiree. On or after July 1, 1999, eligibility ends for a Covered Person who becomes eligible for coverage in a group health plan other than Medicare.

1. Benefits under the Plan for covered dependents of a deceased covered employee or retiree will end on the last day of the month in which the employee or retiree died unless the surviving covered dependents elect to continue coverage.
  - a. The surviving legal spouse of an employee or retiree may continue coverage until the surviving spouse becomes eligible for coverage in a group health plan other than Medicare;
  - b. The surviving never married children of an employee or retiree may continue coverage until they are eligible for coverage under a group health plan other than Medicare, or reaching the termination age for children, whichever occurs first;

- c. Surviving dependents/Spouse will be entitled to receive the same Employer premium contributions as employees and retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851(A)(1)(d)(I) and rules promulgated pursuant thereto by the Office of Group Benefits;
  - d. Coverage provided by the Civilian Health and Medical Program of the Uniform Services will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a dependent child.
2. A surviving spouse or dependent cannot add new dependents to continued coverage other than a child of the deceased employee born after the employee's death.
3. Participant Employer/dependent Responsibilities:
- a. It is the responsibility of your surviving covered dependent to notify your Employer within 60 days of the death of the employee or retiree;
  - b. Your Employer will notify the surviving dependents of their right to continue coverage;
  - c. Application for continued coverage must be made in writing to your Employer within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;
  - d. Coverage for the surviving spouse under this section will continue until the earliest of the following events occurs:
    - i. failure to pay the applicable premium;

- ii. death of the surviving spouse;
  - iii. on or after July 1, 1999, the surviving spouse becomes eligible for coverage under a group health plan other than Medicare.
- e. Coverage for a surviving dependent child under this section will continue until the earliest of the following events:
- i. failure to pay the applicable premium;
  - ii. on or after July 1, 1999, becomes eligible for coverage under any group health plan other than Medicare.
  - iii. reaching the termination age for children.

You cannot be covered under the Definity Health Option as both an employee and a dependent. An individual cannot be covered as a dependent of more than one employee (for example, if both parents are eligible employees, both parents cannot cover the same child under the Definity Health Option). If you are married to another employee of your Employer, you may both elect individual coverage or one of you can elect employee and spouse or employee and family coverage.

### *Annual Open Enrollment*

Unless you are otherwise notified, your participation in the Definity Health Option will continue each year (unless you change it). However, during annual open enrollment, you can elect coverage if you previously declined it, or change your coverage level for the following Plan Year.

### *If You Don't Enroll at Annual Open Enrollment*

#### **Pre-Existing Condition – Overdue (late) Application**

The terms of the following paragraphs apply to all eligible employees who apply for coverage after 30 days from the date the employee became eligible for coverage and to all eligible dependents of employees and retirees for whom the application for coverage was not completed within 30 days from the date the dependent was acquired. The provisions of this section do not apply to military reservists or national guardsmen ordered to active duty who return to state service and reapply for coverage with the plan within 30 days of the date of reemployment. Coverage will be reinstated effective on the date of return to state service.

The effective date of coverage will be:

- a. The first day of the month following the date of receipt by the Plan of all required forms prior to the fifteenth of the month;
- b. The first day of the second month following the date of the receipt by the Plan of all required forms on or after the fifteenth of the month.

The Plan will require that all overdue applicants complete a “Statement of Physical Condition” and an “Acknowledgement of Pre-existing Condition” form.

The terms of the following paragraphs apply to the Health Coverage portion of the Definity Health Option:

### ***Pre-Existing Condition Exclusion***

Medical expenses incurred during the first 12 months that coverage for the employee and/or dependents is in force under the Plan will **not** be considered as covered medical expenses if they are incurred in connection with a disease, illness, accident or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 month period immediately prior to the effective date of coverage. The provisions of this section do not apply to pregnancy. The Pre-Existing Condition Exclusion does not apply to the PCA, preventive care, or prescription drug coverage. This 12 month exclusionary period may be reduced as described below.

### ***Credit for Prior Coverage***

If the covered person was previously covered under a group health plan, Medicare, Medicaid or other “creditable coverage” as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the 12 month exclusionary period will be reduced by the duration of such “creditable coverage,” so long as all such creditable coverage was earned after any “significant break” in coverage

A significant break in coverage occurs when a person has 63 or more consecutive days with no creditable coverage. When a significant break in coverage occurs, all prior creditable coverage is lost.

Note: You may use PCA dollars to pay for covered expenses subject to the pre-existing condition exclusion. Please refer to the section entitled “How Benefit Dollars are Used” on page 8.

### **Special Enrollment**

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

1. **Loss of Other Coverage**

Special enrollment will be permitted for employees or dependents for whom the option to enroll for coverage was previously declined because of the employees or dependents had other coverage which has ended due to:

- a. loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the plan participant; or
- b. cessation of Employer contributions for the other coverage, unless the Employer contributions ended for cause or for failure of the individual participant to make contributions; or
- c. the employees or dependents continuation coverage under a group health plan has been exhausted.

## 2. Dependents Acquired After Enrollment

Special enrollment will be permitted for employees and dependents for whom the option to enroll for coverage was previously declined when the employee acquires a new dependent by marriage, birth, adoption, or placement for adoption.

## 3. The following rules apply to Special Enrollees

- a. A special enrollment application must be made within 30 days of the termination date of the prior coverage or the date the new dependent is acquired. Persons eligible for special enrollment for which an application is made more than 30 days after eligibility will be considered overdue applicants subject to the pre-existing condition limitation.
- b. The effective date of coverage shall be:
  - i. For loss of other coverage or marriage, the first day of the month following the date of receipt by the plan of all required forms for enrollment;
  - ii. For birth of a dependent, the date of birth;
  - iii. For adoption, the date of adoption or placement for adoption.
- c. Special enrollment applicants must complete “Acknowledgement of Pre-Existing Condition” and “Statement of Physical Condition” forms.
- d. Medical expenses incurred during the first 12 months that coverage for the employee and/or dependents is in force under the plan will **not** be considered as covered medical expenses if they are incurred in connection with a disease, illness, accident or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 month period immediately prior to the effective date of coverage. The provisions of this section do not apply to pregnancy. The Pre-Existing Condition

Exclusion does not apply to the PCA, preventive care, or prescription drug coverage. This 12 month exclusionary period may be reduced as described below.

- e. If the covered person was previously covered under a group health plan, Medicare, Medicaid or other “creditable coverage” as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the 12 month exclusionary period will be reduced by the duration of such “creditable coverage,” so long as all such creditable coverage was earned after any “significant break” in coverage

A significant break in coverage occurs when a person has 63 or more consecutive days with no creditable coverage. When a significant break in coverage occurs, all prior creditable coverage is lost.

Note: You may use PCA dollars to pay for covered expenses subject to the pre-existing condition exclusion. Please refer to the section entitled “How Benefit Dollars are Used” on page 8.

### **Retiree Special Enrollment**

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

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

### **Medicare Risk HMO Option for Retirees (Effective July 1, 1999)**

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

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

### **Other Enrollments**

You may also enroll an eligible dependent during the year if a court orders you to cover an eligible dependent (e.g., a QMCSO as discussed on page 31). You must enroll your dependent within 30 days of the court order. Coverage will take effect the first day of the month following the date of receipt by your Employer of all required forms prior to the fifteenth of the month, or the first day of the second month following the date of the receipt by your Employer of all required forms on or after the fifteenth of the month.

### **Benefit Dollars and Deductibles for Mid-Year Enrollments**

If you are hired during the Plan Year and enroll in the Definity Health Option, or enroll mid-year, your Employer will allocate a pro-rated number of Benefit Dollars to your PCA and you will be subject to a prorated Deductible under the Health Coverage Plan.

### **Benefit Dollars and Deductibles for Mid-Year Enrollment Changes**

If you make an allowable change to your coverage level during the Plan Year, in accordance with the section entitled “If You Don’t Enroll at Annual Open Enrollment,” your Employer will adjust the Plan Year Benefit Dollars in your PCA and your Plan Year Deductible to your new coverage tier less the amount of Benefit Dollars you have used and the amount of Deductible you have satisfied during the Plan Year.

### **When Your Coverage Ends**

Your coverage ends on the earliest of the following dates:

- you fail to make a required contribution to the Health Coverage Plan;
- the end of the month in which you terminate employment with your Employer;
- you are no longer an eligible employee under this Plan;
- the Definity Health Option terminates; or
- you die.

### **When Your Dependents' Coverage Ends**

Coverage for your dependents ends on the earliest of the following dates:

- the last day of the month on which your dependent ceases to qualify as a dependent under the Definity Health Option;
- your dependent becomes covered as an employee;
- your dependent is no longer eligible under this plan;
- indicated in a qualified medical child support order;
- your dependent coverage terminates;
- your coverage ends, unless your spouse or dependents qualify for continuation coverage; or
- your Employer terminates the Definity Health Option.

→ **Key Term: Qualified Medical child Support Orders (QMCSO's)**

QMCSO's are state court orders requiring a parent to provide medical support to a child, often because of legal separation or divorce. A QMCSO may require the plans available through the Definity Health Option to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- specifies your last known name and address and the child's last known name and address;
- describes the type of coverage to be provided, or how the type of coverage will be determined;
- states the period to which it applies; and
- specifies each plan to which it applies.

The QMCSO cannot require the Plans to change the type or form of benefits that they offer. The QMCSO may require the Plans to pay benefits to the child or the child's custodial parent. If your Employer and/or Definity Health receive a QMCSO ordering the enrollment of one or more of your children in the Definity Health Option, those children will be enrolled in the Plan, and appropriate payroll deductions will be made for the appropriate premium amounts. Definity Health and/or your Employer will notify you on receipt of a QMCSO affecting your children.

You and the affected child will be notified if an order is received and will be provided with a copy of your Employer's QMCSO procedures.

**Transition of Care**

If you are in the midst of a cycle of treatment or are in your third trimester of pregnancy when your coverage through the Definity Health Option begins, and your provider is not an In-Network provider, you may request that your care continue from your current provider for up to 120 days. If approved, your PCA and the Health Coverage Plan will pay Covered Expenses at 90% of U & C (subject to the Deductible, Coinsurance and other restrictions), until your pregnancy or cycle of treatment is complete.

**This benefit is not automatic.** For more information on how to qualify please call 1.888.DEFINITY (866.333.4648), and choose the care consultant option.

## **Cost**

If your Employer has adopted a cafeteria plan, your Health Coverage Plan premiums may be paid pursuant to a salary reduction arrangement. You are not permitted to make any contribution to your PCA, whether made on a pre-tax or after tax basis. Your PCA is an “unfunded” account, and benefits are payable solely from the general assets of your Employer.

## **What's Covered Under the Definity Health Option**

As shown below, the Personal Care Account and Health Coverage Plan available under the Definity Health Option cover many Medically Necessary services and supplies, subject to certain limits or exclusions in the Plan. Please note: the Health Coverage Plan only covers care provided by healthcare professionals or facilities licensed, certified or otherwise qualified under state law to provide healthcare services.

### **Preventive Care – Scheduled Benefits**

Your Employer believes strongly in not only treating, but preventing, health problems. That's why the Health Coverage Plan covers the following preventive services at 100% for children and up to \$350 per adult per Plan Year — with no Deductible and no need to use your PCA — when you utilize an In or Out of Network provider. The Pre-Existing Condition exclusion does not apply to preventive care.

The Health Coverage Plan covers one routine physical exam per Plan Year plus the laboratory charges and vaccinations as described below. The following is a list of items that are treated as preventive care, and covered under the Health Coverage Plan at 100%.

### ***Well-Child Care***

Well-child care includes the following:

- Routine office visits and examinations:
  - six visits 0 – 12 months
  - three visits 12 – 36 months
  - annual visits from 36 months through age 16
- Immunizations
  - Two doses of Hepatitis A
  - Three doses of Hepatitis B
  - Six doses of Diphtheria, Tetanus, Pertussis (DtaP)
  - Four doses of Haemophilus Influenza type b
  - Four doses of Polio

- Four doses of Pneumococcal Conjugate
- Two doses of Varicella
- Two doses of Measles, Mumps, Rubella
- Screenings
  - Lead level testing, one between ages 9 to 12 months and one between 12 and 24 months
  - Vision screening at ages 3, 4, 5, 6, 8, 10, 12, and 15
  - Hearing screening at ages 4, 5, 6, 8, 10, 12, and 15
  - Pap smear and routine pelvic exam annually beginning at age 16 or the onset of sexual activity, whichever comes first.

### *Well-Adult Care*

Well-adult care includes the following:

- Routine Exams and Office Visits
  - One visit every 3 years from age 16 to age 40 for men
  - Two visits every 3 years from age 16 to age 40 for women
  - One visit every 2 years from age 40 to age 50 for men and women
  - Annual visits from age 50+
- Immunizations
  - Tetanus / Diphtheria (Td) Booster once every 10 years
  - Influenza Vaccination (flu shot) annually
  - Pneumococcal Vaccination (Pneumovaz) one dose for persons 65 and over
- Screenings
  - Annual eye exam
  - Cholesterol screening including triglycerides, LDL, HDL, annually for men age 35 and over and women age 45 and older
  - Mammogram annually starting at age 40
  - Pap Smear and Routine Pelvic Exam once per plan year
  - Bone density test for osteoporosis annually for women age 50 and over.
  - Colorectal Cancer Screenings, you have the choice of the following:

- Fecal occult blood test (FOBT) once per plan year and flexible sigmoidoscopy once every 5 years both beginning at age 50; or
- Colonoscopy once every 10 years beginning at age 50; or
- Double contrast barium enema once every five years starting at age 50
- Digital rectal examination (DRE) and prostate specific antigen (PSA) test once per plan year starting at age 45.

It is important to note that any services that fall outside of the Well-Child Care and Well-Adult Care listed above, including all prescriptions, will not be eligible under this preventive care benefit but may be payable under the PCA and Health Coverage Plan of the Definity Health Option.

 **For More Information**

For more information about preventive care and health and wellness-related products, visit the Definity Health Web site at [www.definityhealth.com](http://www.definityhealth.com).

### **Expenses Covered Under the Definity Health Option**

The Definity Health Option covers a wide range of medical expenses. However, some expenses are covered only under the Personal Care Account, while others are covered under both the PCA and the Health Coverage Plan.

#### **Covered Under the Personal Care Account Only**

Expenses incurred after the Effective Date that would be payable under the Health Coverage Plan but for the annual deductible and any coinsurance or other limitations (lifetime, annual maximum benefits, or other out of pocket limitations) are covered expenses under your PCA. In addition, the following is a list of items that are included only as Covered Expenses under your Personal Care Account:

- amounts over Usual and Customary
- amounts or services in excess of any Health Coverage Plan limits
- difference between brand and generic prescription drugs, if applicable

- amounts not payable because of application of the pre-existing condition exclusion

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

The Internal Revenue Service has specific guidelines that must be followed for many of these items. For more information on a specific benefit, please call 1.866.DEFINITY (866.333.4648).

### **Covered Under the Personal Care Account and the Health Coverage Plan**

Medical expenses covered under both the PCA and the Health Coverage Plan include:

- acupuncture
- allergy injections, testing and serum
- alternative care settings (such as skilled nursing facilities, hospice or home care)
- ambulance service to and from the nearest facility where you can receive needed medical care and services (air ambulance will be covered when it is the only acceptable means of transporting the patient)
- anesthesia
- blood and blood plasma transfusions and blood not donated or replaced
- chemical dependency treatment
- chemotherapy
- chiropractic care
- cochlear implants
- circumcision
- dental care for any of the following:

- repair within six months of accidental injuries to sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan
  - inpatient hospital and anesthesia expenses related to dental work if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition
  - excision of one or more impacted teeth as performed by doctor of dental surgery (D.D.S.) or doctor of dental medicine (D.M.D.) while coverage is in force
- dialysis
  - diabetic supplies and insulin
  - physicians' visits
  - emergency room and urgent care center
  - genetic testing and counseling
  - home infusion therapy when ordered by a physician, including solutions and pharmaceutical additives; pharmacy compounding and dispensing services; ancillary medical supplies; nursing services to train you or your caregiver or to monitor the home infusion therapy, provide emergency care, collection, analysis and reporting of lab tests to monitor response to home infusion therapy, enteral feedings, or other eligible home health supplies and services provided during home infusion therapy.
  - hospital services such as nursing care, drugs and medicines, x-rays and laboratory tests
  - inhalation therapy (provided by a registered or licensed therapist) when needed to correct a functional disorder due to an illness or injury
  - inpatient physician care
  - inpatient rehabilitation
  - mammography
  - massage therapy
  - maternity care (including services and supplies provided by a birthing center or midwife)
  - mental healthcare
  - nutritionists, when required to treat a medical condition
  - occupational therapy (by a licensed therapist)
  - orthotics

- outpatient (ambulatory) surgery
- outpatient cardiac rehabilitation services
- outpatient x-ray and laboratory charges
- oxygen and other gases
- physical therapy (provided by a licensed physical therapist)
- pre-admission testing
- prescription drugs (see section entitled “Prescription Drug Coverage” for more information)
- prosthetic appliances
- pulmonary rehabilitation
- rental (not more than the purchase price) or, if less costly, purchase, of durable medical equipment and related supplies
- semi-private room and board for hospital stays and alternative care settings (private rooms are covered only if medically necessary)
- speech therapy to restore speech lost due to a congenital condition for which corrective surgery cannot be performed, or due to injury or illness
- sterilization
- surgical care (if two or more surgical procedures are performed through the same incision or in the same operative field, the Plan will pay up to 100% of the major procedure and 50% of each additional procedure. If more than one procedure is performed through separate incisions, the Plan will pay up to 100% of the major procedure and 50% for each additional procedure. No additional payment will be made for an incidental procedure performed through the same incision.)
- TMJ (temporomandibular joint syndrome) treatment by a dentist or physician (excludes orthodontic treatment)
- wigs (when needed for hair loss due to cancer or alopecia areata)
- x-ray, radium, radio, isotope treatments

See the section entitled, “Benefit Limits” for limitations and the section entitled “Exclusions Under the Health Coverage Plan” for exclusions.

 **Important Note**

The Mothers' and Newborns' Health Protection Act of 1996 provides that no group health plan or health insurer that provides hospitalization benefits in connection with childbirth may restrict the period of hospitalization after birth for which benefits are payable to less than 48 hours for a vaginal delivery and 96 hours for a cesarean delivery.

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

 **Important Note**

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

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

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

 **What if I'm traveling?**

If you are traveling outside your network and you need medical care, you should contact Customer Service at 1.866.DEFINITY (866.333.4648) or log onto the website at [www.definityhealth.com](http://www.definityhealth.com) for assistance in locating the nearest network provider. If you need emergency care, however, go ahead and get the care you need, and the Definity Health Option will pay Covered Expenses at 90% of billed charges (subject to the Deductible, Coinsurance, and other restrictions) regardless of the provider's network status.

 **What is considered an Emergency?**

*Emergency Care:* Medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health or survival of the individual (or, with respect to a pregnant woman, the health or the woman or her unborn child) in serious jeopardy; or
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

## **Prescription Drug Coverage**

Your pharmacy benefit is designed to cover medications for most diseases, including short term illness such as an ear infection, as well as long term diseases, such as high blood pressure. You will receive maximum value from your pharmacy benefit if you bring your prescription and Definity Health ID card to an In-Network pharmacy. The Pre-Existing Condition exclusion does not apply to prescription drug coverage.

If you do not have your Definity Health ID card with you when you fill your prescription, or if you choose to use an Out-Of-Network pharmacy, you will need to pay for your prescription up front and file a claim for reimbursement. In either case you will be reimbursed only the amount that the Plan would have paid at an In-Network pharmacy with a Definity I.D. card presented.

Your Plan also encourages the use of generic drugs. If generic drugs are available and you select otherwise, you will be expected to pay for a part of your prescription at the pharmacy.

Your prescriptions can be filled through a retail pharmacy, or through mail order services. It is important to know that not every drug is available with your Definity Health ID card through the pharmacy. Your prescriptions will be covered based on the design of your plan (see the Schedule of Benefits) and in accordance with state and federal regulations.

### **① Where to Call**

Most pharmacies participate in the network. To find a pharmacy near you, call Definity Health's Customer Service at 1.866.DEFINITY (866.333.4648) or visit the website at [www.definityhealth.com](http://www.definityhealth.com) and look under the Health Mart or Pharmacy section.

## ***What's Not Covered***

The prescription drug plan does not cover every drug, but some of the drugs it excludes may be provided under other portions of the Health Coverage Plan (i.e., immunizations; see section entitled “Preventive Care – Scheduled Benefits”). Items that are excluded from the prescription drug plan are as follows:

- non-prescription or over the counter medications
- injectable medications administered by a health care provider (except for insulin and depo provera)
- immunizations, vaccines, allergy agents for injection
- blood and blood plasma
- hearing aids
- durable medical equipment such as crutches, wheelchairs, or mobility aids
- non-legend nutritional supplements, except as required for the treatment of PKU (phenylketonuria)
- products used at or dispensed at an outpatient or inpatient facility, clinic, or doctor’s office, including hospitals, extended/nursing care homes, home care service, home infusion services
- products not approved for use in the United States, or experimental therapy. Products purchased outside the United States unless in an emergency situation
- prescription drugs for anyone other than the recipient of the prescription
- prescriptions exceeding a reasonable quantity as determined by your physician in consultation with Definity Health
- growth hormones except for the following indications: adults with hypophyseal dysfunction resulting in symptomatic growth hormone deficiency, pediatric human growth hormone deficiency, gonadal dysgenesis (Turner Syndrome), growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, Prader-Willi Syndrome, adult growth hormone deficiency syndrome, AIDS related cachexia (Serostim only)
- infertility medications except for the following indications: endometriosis, uterine leiomyomata (fibroids), (central) precocious puberty, prostate cancer, hypogonadotropic hypogonadism in males, prepubertal cryptorchidism
- medical devices or equipment
- smoking cessation products
- weight loss medications

- anti-wrinkle medications
- hair growth and hair removal treatments
- cosmetic therapies

### **Definity Health Personal Care Support**

Definity Health has designed a comprehensive care management system called Personal Care Support. It consists of a suite of services designed to provide comprehensive support, including: 1) access to a health coach who can provide coaching, advocacy, and help with care coordination; 2) access by phone and on the web to information regarding costs and quality, to help maximize your healthcare benefit dollars; 3) sophisticated software tools to help you and your physicians identify potential medical errors and patient safety issues; and 4) a notification process for all inpatient admissions and some outpatient procedures.

#### *Health Coach*

If you have a specific medical question you can call 1.866.DEFINITY (866.333.4648) to discuss your situation with a health coach. Health coaches are Registered Nurses and other healthcare professionals who are available 24 hours a day, 365 days a year. They provide information and coaching to you on any health topic over the phone, via the Internet, or through material mailed directly to your home. Depending upon your situation you may be connected to a Definity Health Care Coordinator for further assistance.

#### *Chronic Condition Coaching*

Definity Health provides responsive disease management programs that identify, assess, and support members with specific chronic conditions. Chronic Condition Support is available for:

- Asthma
- Diabetes
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)

If you are interested in one of these programs you may request information from a health coach.

### *Phone and Web Tools*

You can access information on the cost of healthcare services and prescription drugs, find providers in your area, and receive quality information on hospitals via your Definity Health personal member website or by calling 1.866.DEFINITY (866.333.4648).

### *Patient Safety*

Definity Health addresses the issue of patient safety by identifying potential errors in your medical care by using a software program that provides retrospective, claims-based identification of potential medical errors of omission and commission of care. Through this process patients are identified whose care is inconsistent with established standards of clinical excellence. This information can include problems with patient compliance, omissions of effective preventive care, testing or medications, and treatments that may be inappropriate or harmful. Definity Health will notify you and your doctor if potential errors are identified.

### *Notification*

To qualify for maximum benefits under the Health Coverage Plan, please call Definity Health at 1.866.DEFINITY (866.333.4648) **before** a scheduled inpatient admission or certain outpatient procedures. This process helps you receive the best care in the most appropriate facility. Definity Health can assist you with healthcare recommendations, information, and decision support coaching including cost estimates for the procedure, in-network discounts, how the procedure will affect your Personal Care Account, Deductible, and health coverage and possible alternative procedures.

Notification is also important to help you understand how the medical expenses you incur will be paid for under the Health Coverage Plan or through your PCA. For example, it is possible that only part of an extended hospital stay would be “Medically Necessary” under the Health Coverage Plan.

Notification gives Definity Health the opportunity to work with you in advance to reduce the risk of incurring uncovered expenses.

You should notify Definity Health of:

- **All inpatient admissions.** This includes any time you are admitted for an overnight stay including hospital, rehabilitation, hospice, skilled nursing, and mental health or substance abuse facilities. Acute or unexpected admissions require notice within 24 hours of admission; planned or elective admissions require notification seven days before admission, or as soon as you know of the admission.
- **Certain outpatient procedures.** Notify Definity Health of the following procedures as soon as you know of the procedure. If the study is done with no prior notice, notify Definity on the same day of the procedure.
  - MRI Scans (magnetic resonance imaging)
  - Magnetic resonance angiography (MRA)
  - CT or CAT scans (computer aided tomography)
  - Imaging Cardiac Stress Tests (nuclear cardiology, Myoview, myocardial perfusion scans, cardiac echo stress tests)
  - Endoscopic procedures
  - Durable medical equipment (crutches, wheelchairs and accessories, portable oxygen, IV equipment, others)

## **Alternative Care Settings**

There are often times when care can be delivered more comfortably and cost-effectively in an alternative setting, such as a skilled nursing facility, your home, or a hospice. Please notify Definity Health before receiving care in such a setting.

### ***Skilled Nursing Facility***

The Health Coverage Plan pays up to the benefits shown in the Schedule of Benefits for Covered Expenses while the patient is confined as a bed patient in a skilled nursing facility as long as:

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

Covered Expenses include the facility's charge for a semiprivate room and all other eligible services and supplies provided by the facility when the patient is entitled to room and board allowance. Benefits are limited to 120 days per Plan Year of inpatient care.

### ***Home Healthcare***

The Health Coverage Plan pays for Covered Expenses for treatment of a disease or injury in the patient's home instead of a hospital or skilled nursing facility. The charge must be made by a "home healthcare agency." Home healthcare must be prescribed by a physician and given under a "home healthcare plan" in the patient's home. Coverage is limited to 180 visits in a Plan Year by a home healthcare professional. Custodial care is not covered.

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

- part-time or occasional care by a licensed nurse
- intermittent home health aide services
- services of a medical social worker
- physical, occupational, speech and inhalation therapy

- medical supplies and medicines prescribed by a physician
- services of a nutritionist

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

### *Hospice Care*

Hospice care provides supportive care to terminally ill individuals and their families. This care may be provided instead of a hospital confinement when a covered individual is terminally ill and has less than six months to live. The Health Coverage Plan pays for the following services:

- confinement in a licensed hospice facility or skilled nursing facility
- home hospice care provided by a licensed, Medicare-certified hospice team
- nursing care by or under supervision of a registered nurse (R.N.)
- physical and/or occupational therapy
- medical social services
- home health aide services
- counseling
- drugs or medical supplies

### *Emergency Care*

If you need emergency medical care and cannot arrange for care from a network provider, the Health Coverage Plan will pay your claims at 90% of billed charges. Once the emergency has ended, you must use an In-Network provider in order to receive the highest benefit level.

## **Other Covered Services**

In addition, the Health Coverage Plan covers certain special services such as podiatric and chiropractic care, mental health treatment and substance abuse and organ and tissue transplants.

### ***Podiatric Care***

The Health Coverage Plan covers treatment of any condition resulting from weak, unstable or flat feet when an open cutting operation is performed or for treatment of corns, calluses or toenails, when at least part of the nail root is removed. Treatment of bunions is covered when an open cutting operation or arthroscopy is performed.

### ***Chiropractic Care***

The Health Coverage Plan covers chiropractic care provided by a licensed chiropractor within the scope of that licensure, including Medically Necessary exams, manipulations, diagnostic x-rays and laboratory services.

### ***Mental Healthcare and Substance Abuse Treatment Benefits***

The Definity Health Option combines these benefits, but only as follows: each in-patient day or outpatient visit for mental healthcare will reduce the covered in-patient day or outpatient visits for Substance Abuse Treatment. Available mental health in-patient days or outpatient visits are not reduced by any Substance Abuse Treatment in-patient days or outpatient visits treatment.

### ***Mental Healthcare***

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

- hospital
- physician
- licensed consulting psychologist (LCP)
- psychiatrist

- licensed psychologist (LP)
- licensed social worker
- mental health professional

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

The Health Coverage Plan covers up to 45 days of inpatient care and up to 52 outpatient visits for Mental Health. These benefits limits are not reduced by any Substance Abuse benefits received.

### *Substance Abuse Treatment*

Services and supplies for treatment of alcoholism, chemical dependency or drug addiction will be limited to the maximums shown below. The treatment plan must be recommended by a physician and be completed to be eligible for coverage. All care must be provided by licensed, eligible providers—such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care.

The Health Coverage Plan covers up to 45 days of inpatient care and up to 52 outpatient visits for Substance Abuse. These benefits limits are reduced by any Mental Health benefits received.

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

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

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

Bone marrow transplants include stem cells from bone marrow, peripheral blood, and umbilical cord blood sources.

In addition, the transplant program provides living donor coverage for kidney, liver, and bone marrow transplants, testing of potential donors, donor evaluation and workup, and hospital and professional services related to organ procurement. In the case of living donors, the Definity Health Option will coordinate benefits with the donor's health coverage (see section entitled, "Coordination of Benefits").

Coverage is limited to two transplant procedures for the same condition per person subject to the Maximum Individual Lifetime Limit.

When care is provided by a United Resource Network (URN) facility more than 50 miles from the patient's home, the Health Coverage Plan will pay for certain travel and lodging expenses for one person (if the patient is a minor, both parents will receive travel benefits). A per diem allowance of \$50 per person for lodging and \$32 per person for meals will be allowed up to a maximum of \$5,000 per transplant. Definity Health must approve all travel and lodging expenses in advance. Travel and lodging expenses that are not approved in advance will not be paid. **This travel and lodging benefit is not applicable for non-URN facilities.**

### ***Legally Required Expenses Covered***

Notwithstanding the exclusions above with respect to investigational or experimental items or services or costs associated with clinical trials, such items or services required to be covered or paid for by La. R.S. 22:230.4 or La. R.S. 22:215.20 will be covered by the Plan, subject to all other applicable exclusions or limitations. Generally, such items or services involve clinical trials for cancer, if the statutory requirements are met, and drugs prescribed for the treatment of cancer, if such drug is recognized for treatment of the covered indication in a standard reference compendium or in substantially accepted peer-reviewed medical literature. Your Human Resource Department can provide you with a copy of the statutory provisions referenced above. Please contact Definity Health to determine whether a particular item or service is covered under these provisions of the law.

Items which must be covered under the above statutes may be generally described as follows:

Patient costs incurred as a result of a treatment being provided in accordance with a clinical trial for cancer except any applicable copayment, deductible, or coinsurance amounts. Such costs shall include coverage for costs incurred for health related services not otherwise required under La. R.S. 22:215.20.

Costs of investigational treatments and costs of associated protocol- related patient care shall be covered if all of the following criteria are met:

- (1) The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
- (2) The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
- (3) The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
  - (a) one of the United States National Institutes of Health (NIH);
  - (b) a cooperative group funded by one of the NIH;
  - (c) the FDA in the form of an investigational new drug application;
  - (d) the United States Department of Veterans Affairs;
  - (e) the United States Department of Defense;
  - (f) a federally funded general clinical research center;
  - (g) the Coalition of National Cancer Cooperative Groups.
- (4) The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks.
- (5) The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
- (6) There is no clearly superior, non-investigational approach.
- (7) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non- investigational alternative.
- (8) The patient has signed an institutional review board approved consent form.

A drug prescribed for the treatment of cancer, but not approved for such use by the FDA, but which is recognized for treatment of the covered indication in a standard reference compendium or in substantially accepted peer-reviewed literature will be covered. Coverage for a drug covered by this provision shall also include all medically necessary services associated with the administration of the drug. This provision shall not be construed to require coverage for a drug if the FDA has determined its use to be contraindicated for the patient's condition. This provision shall not apply to drugs or services which are furnished in a research trial, if the sponsor of the research trial furnished the drugs or services without charge to participants in the trial.

### ***Pregnancy and Reproductive Care***

The Health Coverage Plan pays pregnancy-related benefits the same as any eligible medical expense. The Health Coverage Plan will cover a 48 hour stay for a normal vaginal birth and a 96 hour stay for a normal cesarean birth.

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

## **Benefit Limits**

### **Creditable Coverage under HIPAA**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), when you lose coverage your Employer must issue a “certificate of creditable coverage” describing the period during which you were a plan participant, the length of COBRA coverage (if applicable) and the plan’s waiting period (if applicable).

“Creditable Coverage” means your prior medical coverage, including other group or individual coverage, Medicare or Medicaid, military-sponsored healthcare, a state health benefits risk pool, a program of the Indian Health Service, the Federal Employees’ Health Benefit Plan, a public health plan or any health benefit under Section 5(e) of the Peace Corps Act.

Any health plan offering group health coverage must reduce any pre-existing condition limit by the length of prior Creditable Coverage. The reduction includes any Waiting Period. In addition, any pre-existing condition limitation under the Health Coverage Plan will not apply to 1) a newborn; 2) an adopted child under the age of 18; or 3) a child placed for adoption under the age of 18; provided they are enrolled under the Health Coverage Plan within 30 days of eligibility. (For example, the Health Coverage Plan has a 12-month pre-existing condition limit. If you were covered under your previous plan for a year or more, the Health Coverage Plan’s pre-existing condition limit will not apply to you). If you have had a break or lapse in coverage for 63 or more consecutive days, you will lose all prior creditable coverage.

### **Pre-existing Conditions**

A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the enrollment date of coverage. The provisions of this section do not apply to pregnancy. The Pre-Existing Condition Exclusion does not apply to the PCA, preventive care, or prescription drug coverage.

If you enroll in the Definity Health Option after you are first eligible to do so and are not entitled to special enrollment rights under HIPAA, the period for determining whether an injury or disease is a pre-existing condition is extended to six months before you enroll in the Definity Health Option. Benefits under the Health Coverage Plan will be payable for a pre-existing condition after you have been covered for more than 12 months after you enroll, reduced by the length of your prior Creditable Coverage.

### **Usual and Customary (U & C)**

The Definity Health Option covers Covered Expenses up to the “usual and customary” amount when an Out-Of-Network provider / facility is used. Usual and customary means **the lesser of:**

- the provider’s usual charge for furnishing the service or supply; or
- the charge the claims administrator determines is reasonable based on the cost of providing the same or similar service or supply in the same geographical area.

To determine the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers, the claims administrator will consider:

- the complexity of the service or supply;
- the degree of skill needed;
- the provider’s specialty;
- the range of services or supplies provided by a facility; and
- similar charges in other areas.

## **Benefit Maximums**

Certain Plan Year and Maximum Individual Lifetime Limits may apply. See the Schedule of Benefits for details.

## Exclusions Under the Health Coverage Plan

In addition to other limits described herein, the Health Coverage Plan does **not** cover charges for:

- treatment, services or supplies that are not Medically Necessary or usual to the treatment of an illness or injury as determined by the Medical Necessity Review Organization retained by the claims administrator to make such determinations
- any illness or injury for which benefits or payments are received (or could be received if claims were made) under any worker's compensation law, Employer's liability law or similar act
- any care of military service connected conditions for which an employee incurred charges while on active duty with the armed services of any country or international organization
- treatment while confined in a state, federal or Veterans Administration hospital for which charges are not imposed
- health services needed from attempting to commit or committing a felony, or engaging in an illegal occupation
- services that are prohibited by law or regulations
- services or confinements ordered by a court or law enforcement officers that are determined by the Medical Necessity Review Organization retained by the claims administrator to make such determinations not to be medically necessary (an initial court-ordered exam for a dependent child under age 18 is considered Medically Necessary)
- health services performed before the effective date or after the termination of coverage under this Plan
- any diagnostic inpatient admission if the test can be performed on an outpatient basis
- any care not recommended and approved by a licensed physician
- any charges of a physician or health professional for services he or she provides to herself or himself or to any close relative (close relative means spouse, brother, sister, parent, grandparent or child and the spouse's brothers, sisters, parents, grandparent or child)
- services rendered by anyone other than a covered healthcare provider
- charges for physician's services for injections that can be self-administered

## **Exclusions Under the Health Coverage Plan cont'd**

- vocational or training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs
- non-medical counseling or training services
- services of the clergy
- services for reversal of sterilization
- non-emergency admissions more than 24 hours in advance of a procedure unless specified by your physician
- any illness or injury for which any benefits are received or could be received if claims were made under any automobile insurance policy to the extent that the policy provides benefits for covered services under the Plan
- personal comfort items while hospitalized such as telephone or television; hospital room and board expenses that exceed the semiprivate room rate unless a private room is approved as medically necessary
- arch supports, foot orthotics or orthopedic shoes not prescribed by a medical doctor, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a medically necessary condition
- biomechanical evaluation, range of motion measurement and reports, and negative mold foot impression
- transportation, other than local ambulance service, for a medical emergency to the nearest hospital that can provide care
- expenses not specifically listed as Covered Expenses under this Plan
- health professional charges for telephone consultation, missed office visits, mailing, shipping and handling expenses, completing any form, or for medical information
- any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community
- charges for the treatment of compulsive gambling
- charges that exceed the allowed amounts and/or the usual and customary charge

## **Exclusions Under the Health Coverage Plan cont'd**

- covered expenses not payable because the applicable Deductible and/or Out-of-Pocket limit has not been met
- expenses eligible for payment under any other plan, including Medicare
- sales tax
- adoption or surrogate expenses
- ventilator-dependent communication services while confined in a hospital or other medical facility
- autopsies
- charges for duplicating and obtaining medical records
- charges for supplies, services or other items or procedures that are determined to be for pre-existing conditions as defined on pages 26 and 55
- augmentative communications devices such as keyboards or voice synthesizers in the case of speech impairments
- breast pumps
- marriage counseling
- lenses, frames and contact lenses; other fabricated optical devices or related professional services including the treatment of refractive errors such as radial keratotomy and laser refractive surgery regardless of medical condition
- vision therapy, except in the case of diabetes
- hearing aids, whether external or implantable or any related expenses
- any dental care, treatment, implants, surgery, or supplies under the medical portion of the Plan, except for the following
  - repair within six months of accidental injuries to sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan
  - inpatient hospital and anesthesia expenses related to dental work if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition
  - excision of one or more impacted teeth as performed by doctor of dental surgery (D.D.S.) or doctor of dental medicine (D.M.D.) while coverage is in force
- charges for or related to fetal tissue transplants

## Exclusions Under the Health Coverage Plan cont'd

- charges related to organ transplants except as specified in the section entitled “Organ, Bone Marrow and Tissue Transplants”
- charges for artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related services or supplies. Artificial support machines while awaiting a human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are covered
- services, chemotherapy, supplies, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered
- non-prescription drugs or medicines; prescription drugs that have not been classified as effective by the FDA; FDA approved therapeutic agents that are not administered according to generally accepted standards of practice in the medical community (Note: some non-FDA approved drugs may be covered as required by law. See section entitled “Legally Required Expenses Covered” on page 52)
- charges for cosmetic or reconstructive surgery and related services, except for the following:
  - reconstructive surgery following a covered mastectomy, as described on page 40
  - surgery to repair a defect caused by an accidental injury resulting in a functional impairment
  - reconstructive surgery related to or following surgery that was needed due to an injury, sickness, or other disease of that part of the body
  - cosmetic or reconstructive surgery to repair a dependent child’s congenital or developmental defect
- charges for sex transformation surgery, hormones related to the surgery and any related expenses

## Exclusions Under the Health Coverage Plan cont'd

- charges for surgery or treatment of an experimental or investigative nature as determined by the claims administrator (this means the medical use of a service or supply that is still under study and that the service or supply is not yet recognized throughout the provider's profession in the U.S. as safe and effective for the diagnosis and treatment of the illness or injury. This includes but is not limited to all phases of clinical trials, all treatment protocols based on or similar to those used in clinical trials; drugs approved by the FDA under its Treatment Investigational New Drug regulation (Note: some investigational services or items in connection with clinical trials may be covered, as required by law. See the section "Legally Required Services Covered" on page 52 for more detail.)
- recreational or educational therapy or other forms of non-medical self care or self-help training including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related services or diagnostic testing
- hypnotism
- phototherapy devices for Seasonal Affective Disorder
- donor ova and sperm and artificial or intrauterine insemination procedures and related services, surgical procedures and prescription drugs for infertility treatment. Services for, or related to, assisted reproductive technology (ART) procedures, including, but not limited to, in vitro fertilization (IVF), gamete intracryopreservation or frozen embryo transfer, unless the procedure is listed as covered
- gene therapy as a treatment for inherited or acquired disorders
- services for, or related to, systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not medically necessary
- liposuction
- full body scans, EBCT (heart scans), except when prescribed for diagnostic rather than preventative or wellness purposes
- expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling
- travel and/or lodging expenses of a physician or a patient, except as specified in the organ transplant section

### **Exclusions Under the Health Coverage Plan cont'd**

- products purchased outside of the United States, unless in an unexpected, emergency situation
- services provided mainly for rest cures, the ease of a household, or sanitarium care
- custodial care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional
- services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a physician
- private duty nursing services
- maternity care for dependent children
- surgery for morbid obesity

## *Medical Necessity Determinations and Appeals*

### **What Does Medically Necessary Mean?**

Medically Necessary means that the service or supply is:

- consistent with the diagnosis of and prescribed course of treatment for the patient's condition or mental disorder; and
- supported by evidence based medical research using valid scientific methods that demonstrate a health benefit from the service or supply, or when none is available based on nationally accepted standards of care; and
- provided by a licensed provider with the appropriate training and experience for the service or supply; and
- not otherwise excluded in this Plan.

The fact that a provider has performed, prescribed or recommended a service or supply or that a service is available does not mean that the service or supply is Medically Necessary or a covered benefit.

Under the Louisiana Medical Necessity Review Organization Act, La. R.S. 22:3070, et seq., ("the MNRO Act") determinations of medical necessity must be made in accordance with certain standards and procedures. The determination of Medical Necessity under this Plan will be made in accordance with the MNRO Act, and any applicable regulations. Subject to the requirements of law, the following is a summary of the procedures to be used to make Medical Necessity determinations and your rights under the MNRO Act.

### *Initial Determinations*

Your Employer has the right to have a determination made of whether supplies, services, drugs or treatment are Medically Necessary under the terms of this Plan. This determination is made by a Medical Necessity Review Organization under contract to Definity Health. Your Employer may not seek Medical Necessity review of emergency services, except to determine if an emergency medical condition existed at the time the services were furnished. If the MNRO determines that an emergency medical condition did not exist at the time the supplies, services, drugs or treatment were furnished, the MNRO may review such supplies, services, drugs or treatment for Medical Necessity in the same manner as any other supplies, services, drugs or treatment for which benefits are sought under this Plan.

All written notices of adverse Medical Necessity determinations shall include:

1. The principal reasons for the determination.
2. Instructions for initiating an appeal or an informal reconsideration of the determination
3. Instructions for requesting the clinical rationale and clinical review criteria used to make the determination

### *Prospective Review*

Initial Determinations of Medical Necessity will be obtained from the Medical Necessity Review Organization (MNRO) automatically by Definity Health or its designee at the time of your request for Pre-Certification or Pre-Authorization (Prospective Review). You and/or your provider will be notified (by the MNRO) of the MNRO's decision. If you do not obtain Pre-Certification of supplies, services, drugs or treatment which require Pre-Certification under this Plan, a reduction in or denial of benefits may be applied, and the Medical Necessity Determination may be made after you have already received services (retrospective review). If the retrospective review by the MNRO reveals that the supplies, services, drugs or treatment were not Medically Necessary, no benefits for such supplies, services, drugs or treatment will be payable under this Plan. If you elect to continue with the a hospitalization, course of treatment, level of care or supplies, services, drugs or treatment after you have been notified that the MNRO has determined that it is not Medically Necessary, you (not your Employer) will be responsible for all charges for such supplies, services, drugs or treatment.

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

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

### *Concurrent Review*

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

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

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

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

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

### ***Retrospective Review***

Your Employer shall have the right to have the MNRO conduct a Medical Necessity review of supplies, drugs or services after they have been furnished (retrospective review). Your Employer will not obtain a retrospective review of supplies, services, drugs or treatment which were Pre-Certified except to determine if fraud or a material omission or misrepresentation was made in connection with the Pre-Certification, or if coverage was cancelled for fraud or non-payment of premiums. If so, your Employer will be allowed to conduct a retrospective review of all supplies, services, drugs or treatment, even those that were Pre-Certified. Your Employer may obtain a retrospective review of any supplies, services, drugs or treatment which were not Pre-Certified, even if those supplies, services, drugs or treatment do not require Pre-Certification under this Plan. You and/or your provider will be notified if the MNRO determines on retrospective review that any supplies, services, drugs or treatment are not Medically Necessary. If the MNRO determines on retrospective review that such supplies, services, drugs or treatment were not Medically Necessary, you (not your Employer) will be responsible for all charges for such supplies, services, drugs or treatment.

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

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

### *Standard Appeals and External Review Procedures*

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

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

### *Informal Reconsideration*

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

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

### ***First Level Standard Appeal***

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

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

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

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

The written notification will contain the following:

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

### ***Standard Second Level Review***

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

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

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

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

At the meeting, you have the following rights:

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

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

Written notification will include:

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

### ***Standard External Review***

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

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

- a. The covered person's pertinent medical records
- b. The treating health care professional's recommendation
- c. Consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider
- d. Any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations

- e. Any applicable clinical review criteria developed exclusively and used by MNRO that are within the appropriate standard of care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria has been reviewed and certified by the appropriate licensing board of Louisiana.

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

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

## *Expedited Appeal and External Review Procedures*

### *Expedited Appeal*

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

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

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

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

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

### *Expedited External Review*

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

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

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

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

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

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

Expedited External Reviews are **BINDING** on you and your Employer to the same extent as Standard External Reviews. This means that both you and your Employer must abide by the decision of the IRO, and that no further review (judicial or otherwise) of Medical Necessity may be sought by either party.

This also means that neither you nor your Employer may sue to have a court determine the issue of Medical Necessity of the supplies, services, drugs or treatment which were the subject of the Expedited External Review.

## Filing Claims

When you receive care from your healthcare provider, you will present your Definity Health ID card. Your provider should submit a claim for payment directly to Definity Health. This amount will be deducted from your Personal Care Account based on your balance at the time Definity Health processes your claim. Once you have used up your Personal Care Account, any additional Covered Expenses you incur will be applied to your Health Coverage Plan's Deductible. Once your Deductible is met, the Plan will pay a portion of your Covered Expenses until you meet the out-of-pocket limit—after which the Plan will pay 100% of any additional Covered Expenses you incur. If your provider does not file a claim on your behalf, follow the procedures under Submitting a Claim, below.



### **Important Note:**

When your claim is processed at Definity Health, two important dates are used:

- The date on which you received a service from your provider is used to process claims for the Health Coverage Plan. This allows your Deductible, Coinsurance, and Out of Pocket Limit to account for the moment in time when you receive healthcare services.
- The date on which Definity Health processes your claim is used when deducting Benefit Dollars from your PCA. This allows the Benefit Dollars in your PCA to act like a savings account, available for your use when your claim is paid.

### ***Submitting a Claim (these procedures only apply when a healthcare provider does not submit a claim on your behalf)***

There may be times when you will be responsible for submitting a claim directly to Definity Health. For example, if you use an out-of-network provider or facility, if you use an out-of-network pharmacy, or if you incur a health expense that is only eligible under your PCA. You may download traditional claim forms from the Definity Health Web site. If you are unable to print a claim form, ask your Human Resources department for a copy. You must include a receipt from your provider (a cancelled check is not sufficient).

You must submit claims to Definity Health promptly but no later than 12 months after the date of the service. **Claims submitted more than 12 months after the date of service are not payable under the Definity Health Option.**

 **Important Note:**

By your application you have agreed to allow all providers to give the Definity Health Option needed information about the care they provide to you. The Definity Health Option keeps all such information strictly confidential.

Benefits will be paid as soon as the necessary information to support the claim is received. All benefits for claims submitted by you are payable to you. However, the Definity Health Option has the right to pay any health benefits to the service provider and will do so, unless you have informed Definity Health otherwise by the time you file the claim.

Separate claims must be filed for each covered individual.

## **Coordination of Benefits**

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

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

### ***How Coordination of Benefits Works***

Covered expenses not reimbursed by the primary plan (see below) will first be paid from your Personal Care Account. If there isn't enough money in your PCA to cover those expenses, the remaining expenses will be submitted to the Health Coverage Plan of the Definity Health Option for payment, subject to applicable Deductible and Co-Insurance provisions.

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

#### **An Example**

Assume your spouse is covered under his or her own Employer's plan and as your dependent under the Definity Health Option, and incurs a \$100 expense for an office visit. Let's also assume the Definity Health Option considers the allowable expense for the office visit is the full \$100. If your spouse's plan covers the visit at 80% (\$80), the Definity Health Option will pay \$20 (\$100 - \$80). In this example you would be reimbursed a total of \$100 (\$80 + \$20).

### *Order of Coverage—Employee and Spouse*

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

### *Order of Coverage—Dependent Children*

For a covered dependent child whose parents are not divorced or separated and who is covered as a dependent under both parents' plans:

- The plan of the parent whose birthday is first in a calendar year will pay benefits first for the covered child. For example, if the father's birthday is in March and the mother's birthday is in September, the father's plan is primary for the child. This is called the "birthday rule."
- If the parents have the same birthday, the plan that has covered a parent longer will pay benefits first for the child. For example, if the father has had coverage under his plan for five years and the mother has had coverage under her plan for seven years, the mother's plan is primary for the child.
- If the other plan does not use the birthday rule but bases the order of benefits on the gender of the parent so that the plans don't agree on order, the rules of the other plan will determine which plan pays first.

If two or more health plans cover a dependent child of divorced or separated parents, benefits for the child are determined as follows:

- If under a court decree the parents have joint custody but the decree doesn't state who is responsible for the child's healthcare expenses, benefits will be coordinated the same as for the children of married parents, described previously.
- The medical plan of the parent who has a court decree of financial responsibility will be primary.
- If no court decree exists, and
  - the parent with custody has not remarried, the medical plan of the custodial parent will be primary.
  - the parent with custody has remarried:
    - the plan of the custodial parent will be primary,
    - the plan of the stepparent will be secondary, and
    - the plan of the non-custodial parent will be third.

### *Coordination with Medicare*

If you keep working for your current Employer and you or a covered dependent becomes eligible for Medicare, the Definity Health Option will remain your primary plan and Medicare will be secondary. Once you retire and elect to remain in Definity Health, Medicare becomes your primary plan and Definity Health will be secondary.

Irrespective of any other provision of the Plan, to the extent permitted by law, Definity Health will use the following rules to coordinate benefits when Medicare is primary:

- 1) Definity Health will determine the benefits which would have been payable for eligible charges incurred under the terms of the Definity Health Option in the absence of Medicare;
- 2) Definity Health will deduct the benefits payable for such eligible charges under the provisions of Medicare, whether or not you are actually covered by Medicare;
- 3) The remaining balance, if any, shall be payable under the Plan, subject to the maximum due under the Definity Health Option. The Deductible and Co-Insurance provisions, if any, will be applied before benefits are paid on this balance.

**Important Note:**

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

Because Definity Health will coordinate benefits for all retirees eligible for Medicare as if such retiree were covered under Medicare Part A and Part B, you are encouraged to enroll in Medicare Part A and Part B when you are eligible.

## **Right of Recovery**

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were made in error or due to a mistake in fact. Benefits paid because you or a dependent misrepresented facts are also subject to recovery.

If the Definity Health Option provides a benefit for you or a covered dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for your or your dependent by the amount of the overpayment.

## ***Third Party Liability***

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

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

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

### *Subrogation*

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

A covered person receiving such payment from the Plan shall sign and deliver all necessary papers to protect the rights of the Plan and Plan Administrator and shall not do anything before or after payment is made by the Plan which would prejudice such rights.

Reimbursement to Plan. The Plan shall be reimbursed for any benefits it paid relating to that Illness, up to the full amount of any recovery or payments received by the covered person, the covered person's legal representative or any other person or organization on account of the Illness, regardless of how the recovery or payments may be characterized. The Plan shall be reimbursed from any settlement, judgment or other recovery before payment of any other existing claims, and may collect from the proceeds of any settlement, judgment or other recovery received or obtained by the covered person, the covered person's legal representative or any other person or organization on account of the Illness, regardless of whether the covered person has been fully compensated or made whole.

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

Recovery first in priority. The Plan's rights of recovery and subrogation will apply even if the covered person has not been made whole for the loss. The Plan's rights of recovery and subrogation shall be in first priority to the extent of any and all benefits paid.

No reduction for costs or attorneys' fees. The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees, and neither the Plan nor the Plan Administrator will pay such costs or fees, unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion. The Plan Administrator also reserves the right to independently pursue and recover paid benefits.

## **Continuing your Coverage**

### **Continuing Coverage During a Leave of Absence**

Depending on your situation, you may be eligible to continue participating in the Plans under the Definity Health Option during a leave or disability.

#### ***Family and Medical Leave Act (FMLA) Leave of Absence***

An employee on approved FMLA leave may retain coverage for the duration of such leave. Your Employer will pay the Employer's share of the premium during FMLA leave, whether paid leave or leave without pay. Your Employer will pay your share of the premium during unpaid FMLA leave, subject to reimbursement by you.

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

If you do not continue coverage under the Definity Health Option during your FMLA leave, you may be entitled to re-enroll in the Definity Health Option upon your return to work. See the section entitled "If You Don't Enroll at Annual Enrollment" for more details.

#### ***Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)***

An employee on Uniformed Services Leave shall be entitled to all benefits and rights provided by the Employer under the Plan to other employees on leave of absence.

"Uniformed Service Leave" means a leave of absence for service in 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 in time of war or emergency.

“USERRA” means the federal Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Leave of Less than 31 Days. If the Uniformed Services Leave is for less than 31 days, and you have elected to continue coverage under the Plan, you may pay for such coverage using any method available to other employees on leave of absence, for a cost not to exceed the sum of the your share and the Employer’s share of the cost of your coverage.

Leave of 31 Days or More. If the Uniformed Services Leave is for 31 days or more, you may elect to continue coverage under the Plan for the lesser of the following periods:

- 18 months beginning on the day that the Uniformed Service Leave commences; or
- a period ending on the day after you fail to return to employment within the time allowed by USERRA.

The Employer may require you to pay 102% of the full premium (the Employer portion and your portion) for the coverage.

If you are still on leave after 18 months, you and your dependents may be eligible to continue medical coverage under COBRA.

Coverage will end if you are discharged from the service under other than honorable conditions, or if you are dismissed or dropped from the rolls under conditions that result in loss of reemployment rights under the law.

### *Employer Approved Leave of Absence*

If you are allowed an approved leave of absence by your Employer, you may retain your coverage for up to one year, if the premium is paid. Failure to do so will result in cancellation of coverage. **You and your Employer must notify Definity Health within 30 days of the effective date of the Leave of Absence.**

### **Continuing Your Coverage through COBRA**

#### **COBRA**

Under federal law, — COBRA, pursuant to the Public Health Service Act — you and your dependents may be eligible to extend group healthcare benefits under the Definity Health Option for a certain period of time. Your rights to extend group healthcare benefits apply jointly to your benefits under the Health Coverage Plan and your Personal Care Account. These rights are summarized below.

**Note: This provision is intended to describe the COBRA law, but it is only a brief summary of the major features of that law. In an individual situation, the law and its clarifications and intent will prevail.**

To continue coverage, you or your covered dependents must pay the full cost of that coverage (your share and your Employer's share) plus a 2% administrative fee. You, your spouse and/or covered dependents, can elect continuation coverage if coverage ends because:

- your employment with your Employer ends for any reason other than gross misconduct;
- your regularly scheduled work hours are reduced to less than full-time;
- your spouse no longer qualifies as a dependent because of your divorce or legal separation;
- your child no longer meets the dependent eligibility requirements; or
- you die.

If you, your spouse and/or your dependents purchase continuation coverage, the coverage will be under the same plan as the coverage lost because of one of these events. However, if the Plan covering employees changes, those changes will also apply to your continuation coverage.

### *How Long Coverage Can Continue*

If you, your spouse and/or a dependent elects continuation coverage, it will begin on the day regular coverage is lost due to one of the previously mentioned events and continue for 18 months. Certain qualifying events may allow coverage to continue beyond 18 months as described below.

### *Extended Coverage*

Your spouse and/or your dependents may be eligible to extend this 18 months of coverage for up to an additional 18 months (36 months total) if:

- you become divorced or legally separated, your child no longer meets the dependent eligibility requirements or you die;
- you become entitled to Medicare coverage during the first 18 months of continuation coverage.

### *Disability Extension*

The 18-month coverage period can be extended to 29 months if:

- you or a qualified dependent is determined to be disabled by the Social Security Administration at the time you qualify for continuation coverage, or you become disabled during the first 60 days of the 18-month continuation coverage period;
- the disability continues throughout the period; and
- you notify your Employer that you are disabled for Social Security purposes before the end of the 18-month period, and within 60 days of such determination.

Your premium contribution for the 11-month extension period will be 150% of the full cost of that coverage (your share plus your Employer's share).

If the disability extension applies to you, your non-disabled family members who currently have continuation coverage may also extend coverage, and may be required to pay 150% of the full cost of that coverage, with certain exceptions.

To qualify for the additional 11 months of coverage, you or your disabled dependent must notify your Employer within 60 days of being classified as disabled by the Social Security Administration. If the Social Security Administration determines that you are no longer disabled, you or your dependent must notify your Employer within 30 days.

### *When Continuation Coverage Ends*

Continuation coverage ends when:

- you, your spouse and/or your dependents do not make the required contributions on a timely basis;
- the person continuing coverage becomes entitled to Medicare;
- the person continuing coverage becomes covered under another group health plan (unless the other group medical plan has a pre-existing condition limitation that affects that person);
- in the case of a maximum 29-month extension due to disability, a determination is made that the individual is no longer disabled (after the first 18 months); or
- your Employer no longer has any group health plan.

Your Human Resources department can provide you and your dependents with more information about continuation and what it will cost to continue coverage.

### *Continuation Notification*

Your Employer is responsible for notifying you, your spouse and/or your dependents of your right to purchase continuation coverage following a change in your employment status with your Employer or upon your death. Such notification will be mailed to your home the designated third-party COBRA administrator.

If there is a change in your spouse's or dependent's status because of your divorce or legal separation, or your child no longer meets the eligibility requirements, you must notify your Employer within 60 days of the end of the pay period in which the change occurs to continue coverage for your dependent. Notify your Human Resources department. Your Employer, through the designated third-party COBRA administrator, will notify your spouse or dependent(s) of their right to purchase continuation coverage. If you do not notify your Employer within 60 days, you and your dependents will not be entitled to continuation coverage.

To extend coverage for up to 29 months due to disability, you must notify your Employer of the disabled person's eligibility for Social Security disability benefits before the first 18 months of continuation coverage ends, and within 60 days of Social Security's determination of benefits eligibility. You must notify your Employer within 30 days if the Social Security Administration determines that the individual is no longer disabled.

### ***How to Purchase Continued Medical Coverage***

You, your spouse and/or your dependents have 60 days to exercise your right to purchase continuation coverage. The 60-day period starts on the date you are notified of your right to purchase continuation coverage or the date regular coverage under the Definity Health Option ends, whichever occurs later. You cannot elect continuation coverage once the 60-day election period ends.

Your Human Resources department will notify you or your dependents of your right to elect continuation coverage. You do not need to provide evidence of good health. If you elect to continue coverage, you have 45 days from the date of your election to make your first payment. Once your continuation coverage begins, the designated third-party administrator must receive your monthly payments within the defined grace period, for your payment to be considered timely.

## **Other Plan Information**

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

### ***Plan Changes and Termination***

Your Employer may terminate, suspend, withdraw, amend, or modify the Plans comprising the Definity Health Option or any portion of such Plans at any time.

### ***Contributions and Benefits***

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

### ***No Employment Rights***

Neither the adoption of the Definity Health Option, nor your status as an employee in any underlying Plan shall constitute a guarantee of continued employment with the Employer. Also, you cannot sell, transfer or assign either voluntarily or involuntarily the value of your benefit under the Plans.

### ***Tax Effect***

Neither your Employer nor Definity Health makes any warranty as to whether any payments or benefits you receive from the Plans offered through the Definity Health Option will be treated as includable in gross income for federal or state income tax purposes.

### ***Plan Year***

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

### ***Amendment or Termination.***

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

### ***Right to Offset Future Payments.***

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

### ***Right to Recover Payments.***

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

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

### ***Misstatements, Misrepresentation, or Fraud.***

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

### *Captions and Headings; Singular or Plural Form.*

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

### *Governing Law*

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

### *Plan Administration and Interpretation*

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

**The Louisiana State University System**  
**3810 W. Lakeshore Drive**  
**Baton Rouge, LA 70808**  
**504-578-6953**

### *Claims Administrator*

The Company has delegated authority to Definity Health to administer benefits under the Definity Health Option. You may contact the Claims Administrator at the following address:

**Definity Health**  
**1600 Utica Ave South, Suite 900**  
**St. Louis Park, MN 55416**  
**952-277-5500**

### *Cost of Administering the Plan*

Your Employer intends to pay certain administrative expenses. The administrative costs of the Plan are paid out of the applicable Plan accounts, unless your Employer (at its sole discretion) chooses to pay those costs.

### *Appealing a Claim*

If you believe an error was made in processing your claim for benefits, you have the right to appeal the decision. If the denial was for lack of Medical Necessity, your appeal rights are as set forth in the section entitled “Medical Necessity Determinations and Appeals” beginning on page 64. If the denial was for any reason other than Medical Necessity, your appeal rights are as follows:

Definity Health will act on your claim within a reasonable period of time, but no later than 90 days after receipt of the claim by the Plan. If Definity Health believes that additional time is necessary to process the claim, it will notify you of the additional time necessary, not to exceed an additional 90 days.

If you are denied a claim for benefits, you will receive in writing within 90 days of receiving the claim:

- an explanation of the specific reason(s) for the denial; and
- specific references to pertinent Plan provisions on which the denial is based; and
- a description of any additional material or information necessary for you to properly establish the claim and an explanation of why such material or information is necessary; and
- an explanation of the steps you or your beneficiary can take to submit the claim for review.

To appeal a denied claim, you or your authorized representative must, within 180 days after receiving the notice of denial, submit a written request to Definity Health or the Plan Administrator asking that your claim be reconsidered. At that time, you or your authorized representative will have the right to review all pertinent plan documents and submit issues and comments in writing. Whenever possible, you should send copies of any documents or records that support your appeal.

A decision regarding your appeal will be made according to the timeframes described below, beginning when your appeal is received by Definity Health or your Plan Administrator. The final decision will be provided to you in writing and will include the reasons for the decision with reference to those Plan provisions upon which the final decision was based.

### *Urgent Care Claims Appeal*

An urgent care claim appeal refers to a claim for which the standard appeal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the judgment of your physician, would subject you to severe pain that cannot be adequately managed without the treatment you are seeking. An urgent care claim appeal is a verbal or written request to have another provider reconsider the decision. An urgent care claim appeal decision will be issued within:

- 72 hours after Definity Health receives the request for an expedited appeal.
- 48 hours after Definity Health receives all necessary information if all necessary information is not available at the time of the request for an expedited appeal.

If Definity needs additional information to process your urgent care claim, Definity will notify you of the additional information required within 24 hours of receipt of the claim.

### *Standard Appeal*

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

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

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

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

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

***Plan Sponsor***

The Health Coverage Plan and the Health Expense Reimbursement Plan are sponsored by:

**Board of Supervisors of  
Louisiana State University and  
Agricultural and Mechanical College  
3810 W. Lakeshore Drive  
Baton Rouge, LA 70808**

***Type of Plan and Plan Number***

The Definity Health Option is comprised of the following two separate plans:

|                                   |                  |
|-----------------------------------|------------------|
| Health Coverage Plan              | Plan Number: 501 |
| Health Expense Reimbursement Plan | Plan Number: 502 |

***Agent for Service of Legal Process***

The agent for service of legal process is:

William L. Jenkins  
Louisiana State University System  
3810 West Lakeshore Drive  
Baton Rouge, LA 70808

***Definitions Applicable to the PCA and the Health Coverage Plan***

The following terms, whenever capitalized, shall have the meaning set forth below unless otherwise specified herein.

"Accidental" means unexpected or unintended bodily injury caused by specific accidental contact with another body or object which is unrelated to any disorder that is:

- a. pathological;

- b. functional; or
- c. structural.

"At Work" means the employee is employed on a full-time duties basis by the Employer.

"Cosmetic Surgery" is any operative procedure performed primarily:

- a. to improve physical appearance; or
- b. to treat a mental or nervous disorder through a change in bodily form; or
- c. to change or restore bodily form without correcting or materially improving a bodily function.

"Creditable Coverage" means the period of time that an individual was covered, without a Significant Break in Coverage occurring after the Creditable Coverage and before the Effective Date, under any other insurance plan that qualifies for Creditable Coverage. Plans that qualify for Creditable Coverage include:

- a. group health plan;
- b. health insurance or health maintenance organization coverage;
- c. Medicare;
- d. Medicaid;
- e. military health care;
- f. a medical care program of the Indian Health Services or of a tribal organization;
- g. a state health benefits risk pool;
- h. a health plan offered under the Federal Employee Health Benefits Program;
- i. a public health plan as defined under Federal regulations;
- j. a health benefit plan under Section 5(e) of the Peace Corps Act; or
- k. any other similar coverage permitted under State/Federal law or regulations.

"Custodial Care" means care that consists of services and supplies provided for hygiene or maintenance care of basic bodily functions or activities of daily living, whether by natural or artificial means. It is care which can be provided by non-professional or non-licensed persons with training, including Respite Care. "Respite Care" is care requested to give temporary relief to persons who normally assist with the care of a Participant.

"Deductible" means the amount of eligible charges which must be incurred before benefits are payable.

"Dependent" means:

- a. the employee's spouse;
- b. the employee's children from birth up to 21 years of age (24 years of age with respect to full-time students); or
- c. the employee's children who are incapable of self-sustaining employment due to mental retardation or physical handicap if said incapacity was incurred prior to the limiting age specified in subparagraph "c." above.

Any person who is covered as an employee shall not be considered a dependent, and no person shall be considered as a dependent of more than one employee.

"Doctor" or "Physician" means a legally licensed Doctor of:

- a. Medicine;
- b. Osteopathy;
- c. Dentistry;
- d. Podiatry;
- e. Chiropractic;
- f. Optometry;
- g. or a social worker, physical therapist, occupational therapist, speech therapist or licensed psychologist.

"Durable Medical Equipment" is equipment which:

- a. can withstand repeated use; and
- b. is primarily and customarily used to serve a medical purpose; and
- c. generally is not useful to a person in the absence of an illness.

"Effective Date" means the date on which the Participant's coverage under this Plan began or the first day of any Waiting Period (if any), whichever is earlier.

"Employee" means a person performing services for the Employer and classified by the Employer as:

- a. an employee or retiree, in the case of Louisiana State University and Agricultural and Mechanical College; or
- b. an employee, member, officer or retiree, in the case of the House of Representatives and Senate of the State of Louisiana.

"Employer" means Board of Supervisors of Louisiana State University and Agricultural and Mechanical College, the House of Representatives and the Senate of the State of Louisiana or any affiliate or successor thereof that subsequently adopts this Plan

"Experimental" or "Investigational" means the use of any services, tests, treatments, supplies, devices, drugs or facilities that:

- a. are not approved by federal or other entities recognized by the medical profession as having special expertise in medical practice; and
- b. are not recognized as accepted medical practice by the Plan Administrator; and
- c. are not approved at the time charges are incurred.

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

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

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

“Home Health Care Visit” means a visit of four consecutive hours within a 24-hour period.

"Hospital" means a facility that is lawfully operated and:

- a. primarily provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as inpatients; and
- b. has a staff of one or more licensed Doctors of medicine available at all times; and
- c. always provides 24-hour nursing service by registered graduate nurses; and
- d. is not primarily a nursing home, rehabilitation center, or a hospital for rest patients and aged patients.

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

"Infertility" means the condition of a person who is unable to conceive or produce conception.

"Infertility treatment" means services, tests, supplies, devices, or drugs which are intended to:

- a. promote fertility; or
- b. achieve a condition of pregnancy; or
- c. treat an illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purpose of this definition, Infertility Treatment includes, but is not limited to:

- a. fertility tests and drugs;
- b. tests and exams done to prepare for or follow through with induced conception;
- c. surgical reversal of a sterilized state which was a result of a previous surgery;
- d. sperm enhancement procedures;
- e. direct attempts to cause pregnancy by any means including, but not limited to:
  - i. hormone therapy or drugs;
  - ii. artificial insemination;
  - iii. in-vitro fertilization;
  - iv. embryo transfer.

"Medically Necessary" or "Medical Necessity" means services or supplies which are determined to be:

- a. consistent with the diagnosis of and prescribed course of treatment for the patient's condition or mental disorder; and
- b. supported by evidence based medical research using valid scientific methods that demonstrate a health benefit from the service, or when none is available based on nationally accepted standards of care; and
- c. provided by a licensed provider with the appropriate training and experience for the service; and
- d. not otherwise excluded in this plan.

The fact that a provider has performed, prescribed or recommended a service or that a service is available does not mean that the service is Medically Necessary or a covered benefit.

The determination whether a service or supply is "Medically Necessary" will be made by a Medical Necessity Review Organization in accordance with the procedures set forth in the section entitled "Medical Necessity Determination and Appeals" beginning on page 64.

"Mental Illness" means a physical or mental condition having an emotional or psychological origin, as defined in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV).

"Morbid Obesity" means either:

- a. a Participant weighs more than 100 pounds over standard weight for height, sex and age; or
- b. a Participant weighs more than two times the standard weight for height, sex and age, whichever is less.

For a Participant who is less than 19 years of age, "Morbid Obesity" means that the Participant's weight is 50% greater than ideal body weight.

"Participant" when referring to the Plan or the PCA, means each Full-Time employee, spouse, and dependent who is eligible for and duly enrolled for coverage in the Plan.

"Participating Provider Organization" or "PPO" means an organization which has contracted with a panel of Participating Providers to furnish, at negotiated costs, medical services and medical supplies to applicable Participants.

"Participating Provider" means a Doctor, pharmacy, Hospital, or other provider of medical services or medical supplies who has entered into an agreement with a PPO.

"Plan Sponsor" means Board of Supervisors of Louisiana State University and Agricultural and Mechanical College.

"Plan Year" means the annual accounting period of the Plan, which begins on each July 1 and ends on June 30 of the following year.

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

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

"Significant Break in Coverage" means that a covered person has a period of 63 or more consecutive days during which such person has no Creditable Coverage.

"Usual and Customary" means the lesser of:

- a. the provider's usual charge for furnishing the service or supply in a Geographical Area; or
- b. the charge the Plan Administrator determines appropriate based on the cost of providing the same or similar service or supply.

To determine the reasonable charge for a service or supply that is unusual, not often provided in the Geographic Area, or provided by only a small number of providers, the Plan Administrator will consider:

- a. the complexity of the service or supply,
- b. the degree of skill needed,
- c. the provider's specialty,
- d. the range of services or supplies provided by a facility and
- e. similar charges in other areas.

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

### ***Definitions Applicable to the PCA Only***

"Benefits" means any amounts paid to a Participant in the Plan as reimbursement for Eligible Health Expenses incurred by the Participant, spouse, or dependent during a Plan Year by him, his Spouse or his dependents.

"Benefit Dollars" means the amounts credited to the Personal Care Accounts of Participants for reimbursement of Eligible Health Expenses incurred by the Participants during a Plan Year, their spouses and dependents. Your Employer may establish a maximum amount of Benefit Dollars. If the amount of Benefit Dollars reaches this limit, no additional allocations of dollars will be made to the PCA in subsequent Plan Years, unless the balance in the employee's Personal Care Account is reduced below the maximum.

“Eligible Health Expenses” means expenses, incurred by the employee, or the employee’s spouse or dependents, after the Effective Date of the employee’s participation herein that would be covered under the Health Coverage Plan but for the annual deductible an any coinsurance or dollars limitations, including lifetime, annual maximum benefits, or other out of pocket charges. In addition, Eligible Health Expenses include the expenses set forth in Summary Plan Description (SPD).

Notwithstanding the above, Eligible Health Expenses must otherwise be allowable as deductions under Code 213(without regard to the limitations contained in Sec 213(a) and provided that amounts reimbursed hereunder are not eligible for deduction under Section 213). Eligible Health Expenses do not include reimbursement for COBRA premiums under any group health plan maintained by the Employer. For purposes of this Plan, an expense is “incurred” when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

“Rollover Dollars” means Benefit Dollars that are not applied to reimbursement of Eligible Health Expenses in any Plan Year shall be carried forward into the next Plan Year, and may accumulate in a Participant’s Personal Care Account throughout a Participant’s Period of Coverage.