PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

CENTENARY COLLEGE OF LOUISIANA GROUP BENEFIT PLAN

EFFECTIVE: JANUARY 1, 2016

RESTATED: JANUARY 1, 2022

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INTRODUCTION

This document is a description of **Centenary College of Louisiana Group Benefit Plan** (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Where a court order, administrative order, judgement, new or changed law or regulation applies to the provisions of this Plan, the Plan will be deemed to have been automatically amended (without further action on the part of the Plan Administrator), to ensure that the Plan conforms to such change. For example, where Plan provisions involve stated maximums, exclusions or limitations, and the change would cause the Plan Administrator to provide greater benefits than what would have been available prior to the change, payment of the greater benefit will be considered to have been made in accordance with the terms of this Plan. For the avoidance of doubt, it is the intent of the Plan Administrator that the Plan conform at all times to the requirements of any and all controlling law, including by way of example and not exclusion, the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

A Plan Participant may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Plan Participant's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

The Claims Administrator utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a

review of currently available clinical information.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Covered Charges. Explains when the benefit applies and the types of charges covered.

Claim Review and Audit Program. Program of claim review and auditing to identify charges billed in error, excessive or unreasonable fees, and charges for services which are not Medically Necessary.

Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Plan Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How to Submit A Claim. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of Injuries sustained.

COBRA Continuation Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Plan Participants' rights under the Plan.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule of Benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are reasonable and customary (as defined as an Allowable Charge); and services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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

PRE-CERTIFICATION REQUIREMENTS

Cigna® will provide pre-certification as required by this Plan.

For medical benefits requiring pre-certification, please contact Cigna® at the toll-free phone number listed on the EBMS/Centenary College of Louisiana Group Benefit Plan identification card prior to seeking treatment or care.

Pre-certification is not a guarantee of benefits, eligibility, payment, nor a medical treatment decision or advice. Please see the Care Management Services section in this booklet for details regarding this pre-certification process.

Please note that Preferred Providers who fail to obtain pre-certification for services that require pre-cert will not be paid for those services and cannot bill the Plan Participant in accordance with the contractual obligation with the Cigna® *network.*

Penalties for failure to obtain pre-certification will not apply to the Non-Preferred Provider maximum out-of-pocket amount.

For other services that do not require pre-certification, **a pre-notification of services is strongly recommended, but not required by the Plan.** Pre-notification is not a guarantee of benefits, eligibility, payment, nor a medical treatment decision or advice.

PROVIDER INFORMATION

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Preferred Providers. Because these Preferred Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Preferred Provider, that Plan Participant will receive better benefits from the Plan than when a Non-Preferred Provider is used. It is the Plan Participant's choice as to which Provider to use.

To access a list of Preferred Providers, please refer to the Preferred Provider website and/or toll-free number listed on the Medical Benefit Plan identification card. Prior to receiving medical care services, the Plan Participant should confirm with the provider and the provider network that the provider is a participant in this organization.

For all Non-Preferred Providers, the Plan will identify the reasonable cost for the services and supplies through its Claim Review and Audit Program.

Under the following circumstances, the higher Preferred Provider payment will be made for certain Non-Preferred Provider services:

- If a Plan Participant has no choice of Preferred Providers within 75 miles of their residence in the specialty that the Plan Participant is seeking.

Covered Charges will be reimbursed at the Preferred Provider benefit level based on the Allowable Charge. The Plan Participant may be balanced billed by the Non-Preferred Provider for any amount over the Allowable Charge.

NO SURPRISES ACT (NSA)

For Non-Preferred Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be the Network benefit level which will be calculated as if the Allowable Charge was the Recognized Amount. Any such cost-sharing amounts will accrue toward the Preferred Provider deductible and maximum out-of-pocket amount. The NSA prohibits Non-Preferred Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Non-Preferred Provider's billed charge for services, except for any applicable cost-sharing.

Non-Preferred Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Preferred Provider at a Network Facility:
  - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;
  - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative and post-operative services regardless of being physically located at the Preferred Facility; and
- Covered Charges for air ambulance services.

Benefit determinations for Non-Preferred Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable, reimbursement will be submitted directly to the Non-Preferred Provider.

Notice and Consent. Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than ancillary services) from a Non-Preferred Provider, and gives written consent to receive those services as Non-Preferred Provider benefits. Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

PROVIDER DIRECTORIES

If a Plan Participant seeks care based on incorrect information indicating that the provider was a Preferred Provider at the time the treatment or service was received, the Plan Participant's cost share will be limited to the Preferred Provider benefit level if the Plan Participant can provide proof within 30 days that they sought care based on the incorrect information.

CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is a receiving treatment from a Preferred Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the Provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former Preferred Provider.

The Plan shall notify the Plan Participant in a timely manner that the Preferred Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former Preferred Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former Preferred Provider or former Network Facility must: (1) accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (2) continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the Preferred Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

(1) undergoing a course of treatment for a serious and complex condition from a specific Preferred Provider;
(2) undergoing a course of institutional or inpatient care from a specific Preferred Provider;
(3) scheduled to undergo non-elective surgery from a specific Preferred Provider, including postoperative care;
(4) pregnant and undergoing a course of treatment for the Pregnancy from a specific Preferred Provider; or
(5) terminally ill and receiving treatment for such illness from a specific Preferred Provider.

DEDUCTIBLES/COPAYMENTS/COINSURANCE/MAXIMUM OUT-OF-POCKET AMOUNT

Deductibles/copayments are dollar amounts that the Plan Participant must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Calendar Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges (except for Covered Charges that are not subject to the deductible).

Each **January 1st,** a new deductible amount is required. The deductible *will apply* to the maximum out-of-pocket amount.

PPO Plan Option - Family unit deductible. When the maximum amount has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that Calendar Year.

HDHP Option - Family Coverage deductible. Covered Employees **with covered Dependents** must meet the Family Coverage deductible amount, as shown in the Schedule of Benefits, without regard to which covered family member incurred the expenses.

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayments do not apply toward the deductible.

Copayments, including Prescription Drug copayments, *will apply to the maximum out-of-pocket amount.*

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is payable by the Plan Participant until the maximum out-of-pocket amount, as shown in the Schedule of Benefits is reached. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Once the Plan has made the applicable benefit payment as shown in the Schedule of Benefits, the remaining percentage owed is the Plan Participant's "coinsurance" responsibility. For example, if the Plan's reimbursement rate is 100%, the Plan Participant's responsibility (or coinsurance) is 0%.

Maximum Out-Of-Pocket Amount

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

PPO Plan Option - Family unit maximum out-of-pocket amount. When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

HDHP Option - Family Coverage maximum out-of-pocket amount. Covered Employees **with covered Dependents** must meet the Family Coverage maximum out-of-pocket amount, as shown in the Schedule of Benefits, without regard to which covered family member incurred the expenses.

SCHEDULE OF BENEFITS – PPO PLAN OPTION

IMPORTANT NOTE: Except as otherwise indicated, benefits for Non-Preferred Providers will be based upon Allowable Claim Limits which are determined under the Claim Review and Audit Program.

PPO PLAN	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Claims should be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Plan Participant	$2,000	$6,000
Per Family Unit	$6,000	$12,000
Note: The Preferred and Non-Preferred Provider deductibles do not apply to each other.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Plan Participant	$6,000	$12,000
Per Family Unit	$12,000	$24,000
Note: The Preferred and Non-Preferred Provider maximum out-of-pocket amount do not apply to each other.		
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%. • Amounts over the Allowable Charge • Penalties for failure to pre-certify • Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies.		
COVERED CHARGES		
Note: The maximums listed below are the total for Preferred and Non-Preferred Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Preferred Providers and Non-Preferred Provider.		
Hospital Services		
Room and Board	80% after deductible Limited to semi-private room rate	50% after deductible Limited to semi-private room rate
Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Intensive Care Unit	80% after deductible Lmited to the Hospital's ICU Charge	50% after deductible Limited to the Hospital's ICU Charge
Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Outpatient Hospital Services/ Outpatient Surgical Center	80% after deductible	50% after deductible
Note: Pre-certification is required for outpatient services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Emergency Room Services	80% after $100 copayment and deductible per visit	
Note: Emergency Room copayment applies to the facility and physician charges and is waived if admitted.		

PPO PLAN	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Skilled Nursing Facility	80% after deductible Limited to 60 days per Calendar Year Limited to semi-private room rate	50% after deductible Limited to 60 days per Calendar Year Limited to semi-private room rate
Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Rehabilitation Services		
Inpatient	80% after deductible Limited to semi-private room rate	50% after deductible Limited to semi-private room rate
Note: Pre-certification is required all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Outpatient (includes speech, physical and occupational therapies, cardiac rehabilitation and pulmonary rehabilitation)	80% after deductible Speech, physical and occupational therapies are limited to a (combined) 60 visits per Calendar Year Cardiac Rehabilitation (including Pulmonary Rehabilitation) is limited to 36 visits per occurance	50% after deductible Speech, physical and occupational therapies are limited to a (combined) 60 visits per Calendar Year Cardiac Rehabilitation (including Pulmonary Rehabilitation) is limited to 36 visits per occurance
Note: Pre-certification is required for speech therapy services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Urgent Care Services	100% after $50 copayment, no deductible applies	50% after deductible
Note: Urgent care copayment includes all services performed during urgent care visit.		
Ambulance Service	80% after deductible	
Physician Services		
Inpatient visits	80% after deductible	50% after deductible
Outpatient visits	80% after deductible	50% after deductible
Office Visits	100% after $50 copayment per visit; no deductible applies	50% after deductible
Note: Office visit copayments include x-rays and labs, allergy injections and radiation treatment when billed with an office visit charge. When surgery is performed in the office, it will be payable under the office visit copayment, but no additional services will be payable under the office visit copayment in addition to the surgery.		
Allergy injection	100% after deductible	50% after deductible
Allergy testing and serum	100% after $50 copayment per visit, no deductible applies	50% after deductible
Note: Copayment will be waived when billed with an office visit charge.		
Surgery (not performed in the office with an office visit charge)	80% after deductible	50% after deductible
Chemotherapy and Radiation Treatment **Wigs (**following chemotherapy and radiation treatment only)	80% after deductible Limited to $500 Lifetime maximum	50% after deductible Limited to $500 Lifetime maximum
Note: Pre-certification is required for chemotherapy and radiation treatment. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		

PPO PLAN	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Diagnostic Testing (x-ray and lab)	80% after deductible	50% after deductible
Imaging Services (MRI, CT/PET Scans, MRA)	80% after deductible	50% after deductible
Note: Pre-certification is required for imaging services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	50% after deductible
Note: Pre-certification is required for durable medical equipment, orthotics and prosthetics. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Hearing Aids	80% after deductible Limited to Plan Participants age 18-65 and limited to 1 hearing aid per ear every 3 Calendar Years	50% after deductible Limited to Plan Participants age 18-65 and limited to limited to 1 hearing aid per ear every 3 Calendar Years
Home Health Care	80% after deductible Limited to 60 visits per Calendar Year	50% after deductible Limited to 60 visits per Calendar Year
Note: Pre-certification is required for home health care. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Home Infusion Therapy/Infusion Therapy	80% after deductible	50% after deductible
Note: Pre-certification is required for home infusion therapy services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Hospice Care	80% after deductible Limited to 60 visits per Calendar Year	50% after deductible Limited to 60 visits per Calendar Year
Infertility	80% after deductible Limited to $20,000 Lifetime maximum	50% after deductible Limited to $20,000 Lifetime maximum
Note: Coverage is limited to services for the diagnosis of Infertility and treatment of the underlying medical condition associated with Infertility.		
Jaw Joint/TMJ	80% after deductible Limited to $1,000 Lifetime maximum	50% after deductible Limited to $1,000 Lifetime maximum
Mental Disorders and Substance Abuse Treatment		
Inpatient Services	80% after deductible	50% after deductible
Note: Pre-certification is required for inpatient services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Outpatient Services	80% after deductible	50% after deductible
Note: Pre-certification is required for outpatient services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Office Visits	100% after $50 copayment per visit; no deductible applies	50% after deductible
Note: Office visit copayments include x-rays and labs, allergy injections and radiation treatment when billed with an office visit charge. When surgery is performed in the office, it will be payable under the office vsiit copayment, but no additional services will be payable under the office visit copayment in addition to the surgery.		
Morbid Obesity (surgical treatment only)	Payable per normal Plan provisions Limited to 1 surgical treatment Lifetime maximum	

PPO PLAN	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Organ Transplants	80% after deductible	50% after deductible
Lodging/Travel/Meals	Limited to $200 per day up to $10,000 Lifetime maximum	Limited to $200 per day up to $10,000 Lifetime maximum
Note: Pre-certification is required for organ transplants. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information. Refer to the Covered Charges section for more information regarding organ transplants.		
Pregnancy – Employee and Spouses only	80% after deductible	50% after deductible
Routine prenatal office visits (Employee and Spouses)	100%, No deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%; thereafter 80% after deductible	50% after deductible
Routine prenatal office visits (Dependent children)	100%, No deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%; thereafter Not Covered	Not Covered
Note: Pre-certification is required for pregnancy services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information. A maternity admission that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery will not require pre-certification. See the Care Management Services section for more information. Refer to the Covered Charges section for more information regarding routine prenatal office visits.		
Routine Well Newborn Nursery Care (while Hospital confined at birth)	80% after deductible	50% after deductible

PPO PLAN	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Preventive Care		
Routine Well Care (birth through adult)	100%, no deductible applies	Not Covered

Routine Well Care Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following website:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Routine Well Care Services will include, but will not be limited to, the following routine services:

Office visits, routine physical exams, prostate screening, routine lab and x-ray services, all immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations.

Note: If applicable, this Plan may comply with a state vaccine assessment program.

Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following websites:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; and
http://www.hrsa.gov/womens-guidelines

Women's Preventive Services, will include, but will not be limited to, the following routine services:

Office visits, well-women visits, mammogram *(including one baseline mammogram exam between the ages of 35-40)*, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, sterilization procedures, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

Diabetic Education	100%, no deductible applies Limited to 3 visits per Calendar Year	Not Covered
Nutritional Education Counseling	100%, no deductible applies Limited to 3 visits per Calendar Year	Not Covered
Obesity Interventions for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher	100%, no deductible applies Limited to 26 visits per Calendar Year	Not Covered
Note: Refer to the Covered Charges section for more information on Obesity Interventions.		
Tobacco/Nicotine Cessation Counseling	100%, no deductible applies Limited to 3 visits per Calendar Year	Not Covered

PPO PLAN	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Private Duty Nursing (outpatient only)	80% after deductible	50% after deductible
Renal Dialysis	80% after deductible	50% after deductible
Note: Refer to the Covered Charges section for more information on Renal Dialysis.		
Spinal Manipulation/ Chiropractic Care	100% after $50 copayment per visit; no deductible applies Limited to 60 visits per Calendar Year	50% after deductible Limited to 60 visits per Calendar Year
Note: Related diagnostic x-rays for chiropractic services are payable as any other diagnostic test.		
All Other Covered Charges	80% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE – PPO PLAN OPTION

Prescription Drug benefits are administered by Veracity Rx powered by ProCare Rx.

	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Retail Pharmacy Option – limited to a 34-day supply per prescription		
Tier 1 Preferred Generic Drugs	$10 per prescription	$10 per prescription
Tier 2 Preferred Brand Drugs	$30 per prescription	$30 per prescription
Tier 3 Non-Preferred Generic/Brand Drugs	$55 per prescription	$55 per prescription
90-Day Retail Pharmacy Option – Available up to a 90-day supply per prescription		
Tier 1 Preferred Generic Drugs	$30 per prescription	$30 per prescription
Tier 2 Preferred Brand Drugs	$90 per prescription	$90 per prescription
Tier 3 Non-Preferred Generic/Brand Drugs	$165 per prescription	$165 per prescription

Note: Except for seizure medications, if a Plan Participant requests a Brand Name drug when a Generic equivalent is available and the prescribing Physician requests a Brand Name drug when not deemed Medically Necessary or has not specified a Brand Name drug is deemed Medically Necessary and is to be Dispensed as Written (DAW), then the Plan Participant will be responsible for the difference in cost between the Generic drug and the Brand Name drug in addition to the Brand Name drug copayment amount.

Additional information regarding the Prescription Drug Benefit may be found in the separate Prescription Drug Benefits section of this document.

SCHEDULE OF BENEFITS – HDHP OPTION

This Plan is intended to be a qualifying High Deductible Health Plan (HDHP).

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) provides coverage for high cost medical events, and in a tax-advantaged way, to help build savings for future medical expenses. The Plan gives a covered Employee greater control over how health care benefits are used. An HDHP satisfies certain statutory requirements with respect to minimum deductibles and maximum out-of-pocket expenses for single and family coverage. These minimum deductibles and limits for out-of-pocket expenses are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

Only those Employees covered under a qualified HDHP are eligible to contribute to an HSA.

If a Covered Person has coverage under this Plan and another plan, the other plan would also need to be a qualified HDHP in order for the Covered Person to contribute to an HSA.

IMPORTANT NOTE: Except as otherwise indicated, benefits for Non-Preferred Providers will be based upon Allowable Claim Limits which are determined under the Claim Review and Audit Program.

HDHP	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Claims should be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.		
DEDUCTIBLE, PER CALENDAR YEAR		
Single Coverage	$3,000	$6,000
Family Coverage	$6,000	$12,000
Note: The Preferred and Non-Preferred Provider deductibles do not apply to each other. This Plan has a "**non-embedded deductible"** which means: **Single Coverage:** Covered Employees **with Employee only coverage** must meet the Single Coverage deductible amount as shown above. **Family Coverage:** Covered Employees **with covered Dependents** must meet the Family Coverage deductible amount, as shown above, without regard to which covered family member incurred the expenses.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Single Coverage	$3,000	$6,200
Family Coverage	$6,000	$12,400
Note: The Preferred and Non-Preferred Provider maximum out-of-pocket amount do not apply to each other		
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%. • Amounts over the Allowable Charge • Penalties for failure to pre-certify • Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies.		

HDHP	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
COVERED CHARGES		
Note: The maximums listed below are the total for Preferred and Non-Preferred Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Preferred Providers and Non-Preferred Provider.		
Hospital Services		
Room and Board	100% after deductible Limited to semi-private room rate	90% after deductible Limited to semi-private room rate
Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Intensive Care Unit	100% after deductible Lmited to the Hospital's ICU Charge	90% after deductible Limited to the Hospital's ICU Charge
Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Outpatient Hospital Services/ Outpatient Surgical Center	100% after deductible	90% after deductible
Note: Pre-certification is required for outpatient services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Emergency Room Services	100% after deductible	
Skilled Nursing Facility	100% after deductible Limited to 60 days per Calendar Year Limited to semi-private room rate	90% after deductible Limited to 60 days per Calendar Year Limited to semi-private room rate
Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Rehabilitation Services		
Inpatient	100% after deductible Limited to semi-private room rate	90% after deductible Limited to semi-private room rate
Note: Pre-certification is required all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Outpatient (includes speech, physical and occupational therapies, cardiac rehabilitation and pulmonary rehabilitation)	100% after deductible Speech, physical and occupational therapies are limited to a (combined) 60 visits per Calendar Year Cardiac Rehabilitation (including Pulmonary Rehabilitation) is limited to 36 visits per occurance	90% after deductible Speech, physical and occupational therapies are limited to a (combined) 60 visits per Calendar Year Cardiac Rehabilitation (including Pulmonary Rehabilitation) is limited to 36 visits per occurance
Note: Pre-certification is required for speech therapy services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		

HDHP	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Urgent Care Services	100% after deductible	90% after deductible
Ambulance Service	100% after deductible	
Physician Services		
Inpatient visits	100% after deductible	90% after deductible
Outpatient visits	100% after deductible	90% after deductible
Office Visits	100% after deductible	90% after deductible
Allergy testing, injection and serum	100% after deductible	90% after deductible
Surgery	100% after deductible	90% after deductible
Chemotherapy and Radiation Treatment **Wigs (**following chemotherapy and radiation treatment only)	100% after deductible Limited to $500 Lifetime maximum	90% after deductible Limited to $500 Lifetime maximum
Note: Pre-certification is required for chemotherapy and radiation treatment. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Diagnostic Testing (x-ray and lab)	100% after deductible	90% after deductible
Imaging Services (MRI, CT/PET Scans, MRA)	100% after deductible	90% after deductible
Note: Pre-certification is required for imaging services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	90% after deductible
Note: Pre-certification is required for durable medical equipment, orthotics and prosthetics. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Hearing Aids	100% after deductible Limited to Plan Participants age 18-65 and limited to 1 hearing aid per ear every 3 Calendar Years	90% after deductible Limited to Plan Participants age 18-65 and limited to 1 hearing aid per ear every 3 Calendar Years
Home Health Care	100% after deductible Limited to 60 visits per Calendar Year	90% after deductible Limited to 60 visits per Calendar Year
Note: Pre-certification is required for home health care. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Home Infusion Therapy/Infusion Therapy	100% after deductible	90% after deductible
Note: Pre-certification is required for home infusion therapy services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Hospice Care	100% after deductible Limited to 60 visits per Calendar Year	90% after deductible Limited to 60 visits per Calendar Year
Infertility	100% after deductible Limited to $20,000 Lifetime maximum	90% after deductible Limited to $20,000 Lifetime maximum
Note: Coverage is limited to services for the diagnosis of Infertility and treatment of the underlying medical condition associated with Infertility.		
Jaw Joint/TMJ	80% after deductible Limited to $1,000 Lifetime maximum	50% after deductible Limited to $1,000 Lifetime maximum

HDHP	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Mental Disorders and Substance Abuse Treatment		
Inpatient Services	100% after deductible	90% after deductible
Note: Pre-certification is required for inpatient services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Outpatient Services	100% after deductible	90% after deductible
Note: Pre-certification is required for outpatient services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.		
Office Visits	100% after deductible	90% after deductible
Morbid Obesity (surgical treatment only)	100% after deductible Limited to 1 surgical treatment Lifetime maximum	90% after deductible Limited to 1 surgical treatment Lifetime maximum
Organ Transplants Lodging/Travel/Meals	100% after deductible Limited to $10,000 Lifetime maximum	90% after deductible Limited to $10,000 Lifetime maximum
Note: Pre-certification is required for organ transplants. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information. Refer to the Covered Charges section for more information regarding organ transplants.		
Pregnancy – Employee and Spouses only	100% after deductible	90% after deductible
Routine prenatal office visits (Employee and Spouses)	100%, No deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%; thereafter 100% after deductible	90% after deductible
Routine prenatal office visits (Dependent children)	100%, No deductible applies *If global maternity fee:* 40% of Covered Charges will be payable at 100%; thereafter Not Covered	Not Covered
Note: Pre-certification is required for pregnancy services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information. A maternity admission that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery will not require pre-certification. See the Care Management Services section for more information. Refer to the Covered Charges section for more information regarding routine prenatal office visits.		
Routine Well Newborn Nursery Care (while Hospital confined at birth)	100% after deductible	90% after deductible

HDHP	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Preventive Care		
Routine Well Care (birth through adult)	100%, no deductible applies	Not Covered
Routine Well Care Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following website: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ **Routine Well Care Services will include, but will not be limited to, the following routine services:** Office visits, routine physical exams, prostate screening, routine lab and x-ray services, all immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations. **Note**: If applicable, this Plan may comply with a state vaccine assessment program. **Women's Preventive Services** will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following websites: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; and http://www.hrsa.gov/womens-guidelines **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, patient education and counseling for all women with reproductive capacity *(this does not include birthing classes)*, sterilization procedures, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.		
Diabetic Education	100%, no deductible applies Limited to 3 visits per Calendar Year	Not Covered
Nutritional Education Counseling	100%, no deductible applies Limited to 3 visits per Calendar Year	Not Covered
Obesity Interventions for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher	100%, no deductible applies Limited to 26 visits per Calendar Year	Not Covered
Note: Refer to the Covered Charges section for more information on Obesity Interventions.		
Tobacco/Nicotine Cessation Counseling	100%, no deductible applies Limited to 3 visits per Calendar Year	Not Covered
Private Duty Nursing (outpatient only)	100% after deductible	90% after deductible
Renal Dialysis	100% after deductible	90% after deductible
Note: Refer to the Covered Charges section for more information on Renal Dialysis.		
Spinal Manipulation/ Chiropractic Care	100% after deductible Limited to 60 visits per Calendar Year	90% after deductible Limited to 60 visits per Calendar Year
All Other Covered Charges	100% after deductible	90% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE –HDHP OPTION

Prescription Drug benefits are administered by Veracity Rx powered by ProCare Rx.

	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Retail Pharmacy Option – limited to a 34-day supply per prescription		
Tier 1 Preferred Generic Drugs	100% after medical deductible per prescription	100% after medical deductible per prescription
Tier 2 Preferred Brand Drugs	100% after medical deductible per prescription	100% after medical deductible per prescription
Tier 3 Non-Preferred Generic/Brand Drugs	100% after medical deductible per prescription	100% after medical deductible per prescription
90-Day Retail Pharmacy Option – Available up to a 90-day supply per prescription		
Tier 1 Preferred Generic Drugs	100% after medical deductible per prescription	100% after medical deductible per prescription
Tier 2 Preferred Brand Drugs	100% after medical deductible per prescription	100% after medical deductible per prescription
Tier 3 Non-Preferred Generic/Brand Drugs	100% after medical deductible per prescription	100% after medical deductible per prescription

Note: Except for seizure medications, if a Plan Participant requests a Brand Name drug when a Generic equivalent is available and the prescribing Physician requests a Brand Name drug when not deemed Medically Necessary or has not specified a Brand Name drug is deemed Medically Necessary and is to be Dispensed as Written (DAW), then the Plan Participant will be responsible for the difference in cost between the Generic drug and the Brand Name drug in addition to the Brand Name drug copayment amount.

Additional information regarding the Prescription Drug Benefit may be found in the separate Prescription Drug Benefits section of this document.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

- All Active Employees of the Employer
- All Retired Employees

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) Is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least **30 hours** per week and is on the regular payroll of the Employer for that work.

The Employer has elected to use the monthly measurement method for all of its Employees to determine Full-Time status. An Employee must average or be expected to average the required minimum hours of service established by the Employer each week to become eligible for coverage. An Employee's initial measurement period begins the first day of the calendar month following the date of hire. To remain eligible for coverage, the Employee must average the required minimum hours of service during each subsequent standard measurement period.

For more information on benefit measurement periods, please contact the Employer's Human Resources Department.

(2) Is in an eligible class.

Eligibility Requirements for Retired Employee Coverage. A person is eligible for Retired Employee coverage if he or she meets the following requirements:

As of January 1, 2020, was enrolled in this Plan as a Retiree.

Note: The former Employee has chosen to continue coverage under the terms of this Plan as a Retired Employee, and forfeits their right to elect COBRA Continuation Coverage at a later date. If, at the time of retirement, the former covered Employee chooses to continue coverage under COBRA Continuation Coverage, he or she will forfeit any right for coverage under this Plan as a Retired Employee.

Eligible Classes of Dependents. A "**Dependent**" is any one of the following persons:

(1) A covered **Employee's Spouse.**

The term **"Spouse"** shall mean an individual of the **opposite sex or same sex** recognized as the covered Employee's husband or wife by the laws of the state in which the marriage was formalized including Domestic Partners. This definition does not include common-law marriage, or civil unions.

The term **"Domestic Partner"** shall mean the person of the opposite sex or same sex who is

currently registered with the Employer as the Domestic Partner of the Employee.

An individual is a Domestic Partner of a covered Employee if that individual and the covered Employee meet each of the following requirements:

(a) The covered Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract;

(b) The covered Employee and the individual are not married or in a domestic partnership to anyone else;

(c) The covered Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside;

(d) The covered Employee and the individual share the same principal residence(s); and

(e) The domestic partnership must have been in existence for a period of at least 12 consecutive months.

To obtain more detailed information or to apply for this benefit, the covered Employee must contact the Plan Administrator. In the event the domestic partnership is terminated, either partner is required to inform the Plan Administrator of the termination of the domestic partnership.

Spouses of Retired Employees who are 65 or older who elect Medicare coverage will not have coverage under this Plan.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(2) A covered **Employee's Dependent child(ren).**

A covered Employee's "**Dependent child**" includes natural child, stepchild, Foster Child, adopted child, or a child placed with the covered Employee in anticipation of adoption. A Dependent child will be eligible until reaching the limiting age of 26. When the Dependent child reaches the limiting age, coverage will end on the last day of the child's birthday month. Coverage is available to the Dependent children of the Domestic Partner provided that the children otherwise meet the Dependent child eligibility requirements of the Plan.

If a covered Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase **"child placed with a covered Employee in anticipation of adoption"** refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e., Domestic Partner or non-IRC Section 152 Dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

(3) A **covered Dependent child who reaches the limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee, for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the covered Employee's home but who are not eligible as defined; the legally separated or the divorced former Spouse of the Employee; or any person who is covered under the Plan as an Employee.

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

If both parents are Employees and/or Retired Employees, their children may be covered as Dependent children for one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Dependent child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan.

For Employee and Dependent Coverage: The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employee.

For Retired Employee Coverage: The Retired Employee pays the entire cost of Retired Employee coverage under this Plan.

The level of any Employee/Retired Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee/Retired Employee contributions.

ENROLLMENT

Enrollment Requirements.

An Employee must enroll for coverage by completing an enrollment application along with the appropriate payroll deduction authorization, if applicable. If Dependent coverage is desired, the covered Employee will be required to enroll the Dependent(s).

Enrollment Requirements for Newborn Children.

A newborn child of an Employee **is not** automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

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

Coverage begins as stated in the Open Enrollment section below.

Open Enrollment - Each year there is an annual open enrollment period designated by the Employer during which eligible Employees may enroll themselves and any eligible Dependents under the Plan, or covered Employees may change their and their covered Dependents' benefit elections under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective **January 1.**

Plan Participants will receive detailed information regarding open enrollment from their Employer.

(3) **Enrollment Following Benefit Measurement Period** - Employees who were determined to be Full-Time Active Employees during the applicable measurement period (and their eligible Dependents may enroll in the Plan the first day of the first full calendar month of the following stability period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, domestic partnership, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, registration of the domestic partnership, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. **To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.**

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period (***Note:*** *A Retired Employee who declines coverage at retirement and later loses other coverage* ***will not*** *be entitled to special enrollment, nor will the Retired Employee's eligible Spouse or Dependent children.*).

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual; and

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment; and

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated; and

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin on the date of loss.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, termination of domestic partnership, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death, termination of employment, or reduction in the number of hours of

employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee, or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or the Employee is eligible, but not enrolled in this Plan), and

(b) A person becomes a Dependent of the Employee through marriage, domestic partnership, birth, adoption, or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll. *If the Retired Employee is not enrolled at the time of the event, this Special Enrollment right **will not** be applicable.*

The Special Enrollment Period for newly eligible Dependents is a period of **30 days** that begins after the date of the marriage, registration of domestic partnership, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this **30-day** period. In the case of birth, adoption, or placement for adoption, the Spouse of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

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

(i) in the case of marriage or domestic partnership, as of the date of marriage or registration of domestic partnership;

(ii) in the case of a Dependent's birth, as of the date of birth;

(iii) in the case of a Dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption.

(3) Medicaid or Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan, but who are not enrolled, can enroll in the Plan provided they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility if:

(a) The Employee or Dependent cease to be eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage; or

(b) The Employee or Dependent become newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Employee and/or Dependent may enroll under this Plan. If the Employee is not enrolled at the time of the event, he or she must enroll under this Special Enrollment Period in order for their eligible Dependent to enroll.

This Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. The effective date of coverage will be the first day of the first month following the date of loss of coverage or gain in eligibility.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees.

For more information regarding special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retired Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or Retired Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retired Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated;

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes, or, if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;

(4) The date in which the Retired Employee who is 65 or older **and** elects Medicare coverage.

(5) The date in which the Retired Employee has access to an Employer sponsored healthcare Plan through the employment of the Retired Employee or the employment of the Retired Employee's Spouse.

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(6) As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. Coverage for an Employee and enrolled Dependents may be continued for a limited period of time if Active, full-time work ceases due to disability or leave of absence. This continuance will end as follows:

For disability or leave of absence: The end of the **90-day** period that next follows the month in which the person last worked as an Active Employee.

If the Employee was on the Employer's payroll as an hourly Employee and enrolled in the Plan immediately prior to the designated leave (Employer-certified disability, leave of absence, paid administrative leave, or after injury or illness covered by Workers' Compensation), the Employee's eligibility shall continue until the last day of the applicable stability period if the stability period ends prior to the end of the designated leave period.

If Employee's leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which the Employee may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

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

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

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

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

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

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

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

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated;

(2) The date that the Employee's or Retired Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);

(3) For the Spouse of a Retired Employee, the date the Spouse who is 65 or older and has elected Medicare.

(4) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.);

(5) The last day of the calendar month in which a Dependent child ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.);

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

(7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(8) As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.]

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness and while the Plan Participant is covered for these benefits under the Plan.

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be payable at the average private room rate of that facility.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(2) **Coverage of Pregnancy.** The Allowable Charge for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse, and will be payable as stated in the Schedule of Benefits.

Note: Routine prenatal office visits will be payable as stated under the Pregnancy benefit as shown in the Schedule of Benefits section. The following services will continue to be payable per normal Plan provisions (and ***will not*** apply to the Pregnancy of a Dependent child):

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

There is no coverage of Pregnancy for a Dependent child. *However, the following services are available to all female Plan Participants and are payable as stated in the Schedule of Benefits, patient education and counseling for all women with reproductive capacity, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth, and any other service required to be covered as preventive for pregnant women under the ACA.*

Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if admitted within 14 days of discharge from Hospital confinement and when:

(a) the Plan Participant is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is deemed Medically Necessary; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Plan Participant's care in these facilities are payable as described in the Schedule of Benefits.

Note: Pre-certification is required for skilled nursing facility care. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement:

(a) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Note: Pre-certification is required for home health care. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(6) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a healthcare provider acting within the scope of his or her license for the Plan Participant's immediate family (covered Employee, covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

(7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy**. Care, supplies, services and treatment in connection with allergy testing, serum and injections.

(b) **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(c) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(d) **Applied Behavioral Analysis** or other similar services when provided by a Physician or an individual licensed by the behavioral analyst certification board or certified by the Department of Public Health and Human Services as a family support specialist with an

autism endorsement for covered Dependents.

Note: Benefits are limited to treatment that is prescribed by a Physician and documented by a written Plan of Care provided by the treating Physician. The Plan Administrator may request periodic documentation of continued progress to goals identified in the Plan of Care.

(e) **Breast pump, breast pump supplies, lactation support and counseling**.

Breast pump, breast pump supplies
A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.

- For female Plan Participants using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.

- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits section.

Note: *Breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the Preferred Provider benefit level for the purposes of this benefit.*

The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.

Lactation support and counseling
Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Plan Participants for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: *Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Schedule of Benefits section will be considered payable at the Preferred Provider benefit level for the purposes of this benefit*

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services up to the limits as stated in the Schedule of Benefits are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(g) **Chemotherapy or radiation treatment** with radioactive substances. The materials and services of technicians are included.

Note: Pre-certification is required for chemotherapy and radiation treatment. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(h) **Cleft Lip and Cleft Palate services.** Charges for the treatment and correction of cleft lip and cleft palate including the following:

- Oral and facial surgery, surgical management and follow up care;
- Prosthetic treatment, such as obturators, speech appliances and feeding appliances;
- Orthodontic treatment and management;
- Preventive and restorative dentistry to insure good health and adequate dental structures or orthodontic treatment or prosthetic management or therapy;
- Speech-language evaluations and therapy;
- Audiological assessment and amplification devices. *Note: Amplification devices for the purpose of treating cleft lip and cleft palates will not be subject to the limits as of the hearing aid benefit as shown in the Schedule of Benefits*;
- Otolaryngology treatment and management;
- Psychological assessment and counseling; and
- Genetic assessment and counseling for parent and patient.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

(i) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial.
- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
- The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays,

clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

Routine patient services do not include, and reimbursement will not be provided for:

- The investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g. monthly CT scans for a condition usually requiring only a single scan);
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Note: Pre-certification is required for experimental/investigational/unproven procedures. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(j) Initial **contact lenses** or glasses required following cataract surgery.

(k) **Contraceptives**. All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs) and implants, (including insertion and removal when applicable), injections, and any related Physician and facility charges including complications. Services will be payable subject to the Preventive Care benefit in the Schedule of Benefits.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants.

(l) **Diabetic Education.** Inpatient and outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, will be payable up to the limits as stated in the Schedule of Benefits.

(m) **Dietitian visit.** Charges for one dietitian visit per Calendar Year are covered at no cost to the Plan Participant when performed by a Preferred Provider. There will not be any coverage when provided by a non-Preferred Provider.

(n) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant;

- Does NOT have significant non-medical uses (i.e. air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly. The acquisition cost of the item may be prorated over a six-month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Calendar Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the four-Calendar Year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the four-Calendar Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Calendar Year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

Note: Pre-certification is required for durable medical equipment. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(o) **Hearing Aids.** Charges for services or supplies in connection with hearing aids up to the limits as stated in the Schedule of Benefits.

(p) **Home Infusion Therapy/Infusion Therapy.**

Home Infusion Therapy. The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are

required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor a response to therapy.

Infusion Therapy. Medically Necessary Physician-prescribed administration of fluids, nutrition, or medication by intravenous or gastrointestinal (enteral) infusion or by intravenous injection. Covered Charges under this benefit include Prescription Drugs, nursing and administrative services.

Note: Pre-certification is required for home infusion therapy. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(q) **Infertility.** Care, supplies and services for the diagnosis of Infertility and treatment of the underlying medical condition associated with Infertility.

(r) **Laboratory studies.** Covered Charges for diagnostic lab testing and services.

(s) **Mental Disorders and Substance Abuse**. Covered Charges will be payable for care, supplies and treatment of Mental Disorders and Substance Abuse.

Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(t) **Morbid Obesity.** Charges for diagnostic testing and surgical procedures for the treatment of Morbid Obesity when deemed Medically Necessary, will be payable up to the limits as stated in the Schedule of Benefits.

Coverage is limited to the following procedures:

- Laparoscopic gastric restrictive procedure with placement of adjustable gastric restrictive device (CPT 43770, 43771, 43772, 43773 & 43774)
- Laparoscopic gastric restrictive procedure through longitudinal gastrectomy (CPT 43775)
- Laparoscopic gastric restrictive procedure with gastric bypass and Roux-en-Y gastroenterostomy (CPT 43644)

Any procedure not listed above will not be a Covered Charge under this Plan.

A pre-notification of services, by the Plan Participant is strongly recommended for either inpatient or outpatient surgical procedures and will require the following documentation including, but not limited to, a written treatment plan by the attending Physician and documentation that all required medical criteria in advance of any surgical treatment has been met.

Covered Charges will include Physician's office visits, related laboratory testing, surgical treatment, including complications whether direct or indirect, including dietary

counseling and prescription medications for weight loss.

The measurement of Body Mass Index (BMI) as defined under this Plan or a BMI of 35 or greater with any co morbid conditions that are expected to improve, reverse or be limited by this surgical treatment and which must be documented in a record or letter of medical necessity must demonstrate the diagnosis of Morbid Obesity.

A pre-notification of services by the Claims Administrator is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan including, but not limited to, medical necessity, exclusions, and limitations in effect when charges are incurred. A pre-notification is not required as a condition to paying benefits and cannot be appealed.

(u) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Extraction of impacted teeth.

Dental anesthesia and facility charges. Administration of general anesthesia and facility or office charges for dental care will be a Covered Charge for covered Dependent children; for a Plan Participant who is physically or developmentally disabled who has a dental condition that cannot be safely and effectively treated in a dental office; for a person who sustained extensive facial or dental trauma; or for a Plan Participant who has a comorbid medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(v) **Nutritional Education Counseling.** Care, treatment, and services when provided by a health care provider acting within the scope of his or her license, will be payable up to the limits as stated in the Schedule of Benefits. *This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.*

(w) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity (up to 26 visits per Calendar Year) encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care and treatment and Physician prescribed weight loss medications **will not** be a covered benefit except as may be specifically described as a benefit by this Plan.

This Plan **will not** cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g. Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(x) **Occupational therapy** by a health care provider acting within the scope of his or her license payable up to the limits as shown in the Schedule of Benefits. Therapy must be ordered by a Physician, result from an Injury or Illness including autism spectrum disorders and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition.

(y) **Organ transplant.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational, subject to the following criteria:

- The transplant must be performed to replace an organ or tissue.

- Organ transplant benefit period: A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- Organ procurement limits. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan Participant. When the donor has medical coverage, his or her Plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's Plan. Donor charges include those for:

  (i) Evaluating the organ or tissue;
  (ii) Removing the organ or tissue from the donor; and
  (iii) Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed.

Note: Expenses related to the purchase of any organ will not be covered.

A Cigna LIFESOURCE Transplant Network® facility is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Plan Participant may contact the Claims Administrator to determine whether or not a facility is considered a Cigna LIFESOURCE Transplant Network® facility.

Travel and Lodging Expenses

If a transplant is performed at a Cigna LIFESOURCE Transplant Network® facility and the Plan Participant resides 100 miles or more from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period (subject to the maximum benefit as specifically stated in the Schedule of Benefits):

A. Transportation expenses to and from the Cigna LIFESOURCE Transplant Network® facility for the following individuals:

- The Plan Participant; and
- One or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child); or
- One adult to accompany the Plan Participant.
- Living donor (if applicable under the Plan)

Transportation expenses include commercial transportation (coach class only).

B. Reasonable lodging and meal expenses incurred for the living donor, Plan Participant, and one or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child), or one adult companion who is accompanying the Plan Participant, only while the Plan Participant is receiving transplant-related services at a Cigna LIFESOURCE Transplant Network® facility.

Lodging, for purposes of this Plan, will not include private residences.

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health Plan and/or a Plan Participant participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact Cigna as soon as reasonably possible so that the Plan can advise the Plan Participant or his or her Physician of the transplant benefits that may be available.

Transplant Exclusions

Coverage for the following procedures, when Medically Necessary, may be provided under the regular medical benefits provision under this Plan, subject to all Plan provisions and applicable benefit limitations as stated under this Plan:

- Cornea transplantation
- Skin grafts
- Artery

- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(z) **Orthotics.** The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

Replacements are covered only within a reasonable time period as determined by the date of purchase and the expected lifetime of the device.

Note: Pre-certification is required for orthotics. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(aa) **Physical therapy** by a health care provider acting within the scope of his or her license will be payable up to the limits as shown in the Schedule of Benefits. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy including treatment of autism spectrum disorders.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition.

(bb) **Prescription** Drugs (as defined). Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefits section of this Plan.

(cc) **Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as described in the Schedule of Benefits.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

Consult with your Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

(dd) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse including continuous skilled care or intermittent care by a Registered Nurse (R.N), Licensed Practical Nurse or Licensed Vocational Nurse while a patient is not confined in the Hospital. Inpatient private duty nursing is not a Covered Charge.

(ee) **Prosthetics.** The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts.

Replacements are covered only within a reasonable time period as determined by the date of purchase and the expected lifetime of the device.

Note: Pre-certification is required for prosthetics. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(ff) **Pulmonary Rehabilitation.** Charges for pulmonary rehabilitation services with a Physician's written treatment plan.

(gg) **Reconstructive Surgery.** Correction of abnormal congenital conditions, deformity due to surgery, restoring to normal function following Injury or Illness and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

(hh) **Rehabilitation Services.** Charges for inpatient rehabilitation services must be Medically Necessary to restore and/or improve a bodily function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Plan Participant received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

Note: Pre-certification is required for all inpatient admissions. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(ii) **Renal Dialysis Services**. Renal dialysis visits shall include dialysis, facility services, supplies and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

(jj) **Sleep studies**. Services related to the diagnosis and treatment of a Medically Necessary sleep disturbance or disorder.

Note: Pre-certification is required for sleep management procedures. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(kk) **Speech therapy** by a health care provider acting within the scope of his or her license payable up to the limits shown in the Schedule of Benefits. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; (iii) an Illness; or (iv) in treatment of a autism spectrum disorder.

The Plan may require a documented Plan of Care that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition.

Note: Pre-certification is required for speech therapy. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

(ll) **Spinal Manipulation/Chiropractic services** by a health care provider acting within the scope of his or her license, payable up to the limits as stated in the Schedule of Benefits.

(mm) **Sterilization** procedures. Sterilization procedures for female Plan Participants will be payable under the Preventive Care benefit as stated in the Schedule of Benefits.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
- Sterilization procedures for male Plan Participants

(nn) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(oo) **Telehealth.** Charges will be subject to the same deductible, copayment, or coinsurance requirements as if the services were provided in person.

(pp) **Temporomandibular Joint Syndrome**. All diagnostic, treatment and surgical procedures related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome, including associated musculature and neurological conditions.

(qq) **Tobacco/Nicotine Cessation Counseling.** Care and treatment for tobacco/nicotine cessation counseling, will be payable up to the limits as stated in the Schedule of Benefits. Refer to the Prescription Drug Benefit section regarding coverage of tobacco/nicotine cessation medications and products.

(rr) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal well-baby care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an **eligible and enrolled** Dependent and a parent (1) is a Plan Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for routine well-baby nursery care for the

newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent, provided the newborn child is enrolled on a timely basis.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges for routine well-baby care made by a Physician for pediatric visits to the newborn child while Hospital confined, including circumcision, as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent, provided the newborn child is enrolled on a timely basis.

(ss) **Wig.** Charges associated with the purchase of a wig after chemotherapy or radiation treatment and will be payable up to the limit as stated in the Schedule of Benefits.

(TT) **X-rays**. Covered Charges for diagnostic x-rays and imaging services.

Note: Pre-certification is required for imaging services. Failure to obtain pre-certification may result in a reduction in benefit payment for non-Preferred Providers. See the Care Management Services section for more information.

CLAIM REVIEW AND AUDIT PROGRAM

The Plan has arranged for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Plan Participants; and, in return, the provider must agree not to bill the Plan Participant for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Plan Participant to file an appeal under the Plan. Please refer to the section, "Internal and External Claims Review Procedures" for additional information regarding Plan Participant and provider appeals.

Any Plan Participant who receives a balance-due billing from a medical care provider for these charges should contact the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Plan Information section of this Plan Document and Summary Plan Description.

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as deductibles, coinsurance and copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Charges that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Plan Participant. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under applicable regulations, it will be necessary to deny the claim. Should such a denial be necessary, the Plan Participant and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Internal and External Claims Review Procedures" in this Plan Document and Summary Plan Description.

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

(1) **Errors, Unbundled and/or Unsubstantiated Charges.** Allowable Claim Limits will not include the following amounts:

(a) Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;

(b) Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;

(c) Charges that cannot be identified or understood; and

(d) Charges that cannot be verified from audits of medical records.

(2) Guidelines. The following guidelines will be used when determining Allowable Claim Limits:

(a) Facilities. The Allowable Claim Limit for claims by a Facility, including but not limited to, hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care Facility, shall be the greater of (I) 112% of the Facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. If insufficient information is available to identify either the Facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

(b) Outpatient Surgical Centers. The Allowable Claim Limit for Outpatient Surgical Centers, including ambulatory surgery centers, which are independent facilities, shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

(c) Professional Providers. The Allowable Claim Limits for professional providers shall be determined using the following:

(i) For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;
(ii) For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;
(iii) For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%;
(iv) For ambulance and air ambulance claims, the Medicare allowed amount in the geographic area plus an additional 20%; or
(v) For other non-Facility claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories (i), (ii), (iii), (iv), or (v) above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

(d) Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted

Providers shall be the negotiated rate as agreed under the Direct Agreement.

(e) **Insufficient Information to Determine Allowable Claim Limit.** In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, the Plan Administrator may apply the following guidelines:

(i) **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered service may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

(ii) **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

(iii) **Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Plan Participant.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical Plan of Care, and advocates patient involvement in choosing a medical Plan of Care. Utilization Management begins with the pre-certification process.

PRE-CERTIFICATION

Pre-certification is required by the Plan for the specific services provided by non-Preferred Providers as outlined below. Pre-certification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. A pre-certification of services is performed by Cigna® or a Cigna Designee and is not a determination by the Plan that a claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

To obtain pre-certification, call the toll free number listed on the EBMS/Centenary College of Louisiana Group Benefit Plan identification card prior to seeking treatment or care.

Penalty for failure to obtain pre-certification for services performed by a non-Preferred Provider will be a **denial of coverage**. Penalties do not apply toward the non-Preferred Provider maximum out-of-pocket amount.

HOW PRE-CERTIFICATION WORKS

Before a Plan Participant is admitted to a Hospital (other than due to a Medical Emergency or a routine delivery maternity admission) or upon receiving notification of the potential need for an organ transplant, the Plan Participant and/or their attending Physician needs to call the toll free number listed on the **EBMS/Centenary College of Louisiana Group Benefit Plan identification card** who, in conjunction with the attending Physician, will obtain information for the purpose of pre-certifying the care as appropriate for Plan reimbursement.

Pre-certification must occur at least **48 hours** in advance of planned **inpatient admissions and other certain services**. A maternity admission that does not exceed 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery will not require pre-certification whether performed by a Preferred Provider or not.

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

Pre-certification is required for the following services:

- **Inpatient Hospitalizations, excluding maternity admission length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery;**
- **Inpatient admissions to free-standing Substance Abuse, Mental Disorder, Rehabilitation and Skilled Nursing facilities;**
- **Organ Transplants;**
- **Chemotherapy and radiation treatment not performed in the office;**

- **J Code Drugs in excess of $2,500;**
- **Inpatient Hospice Care;**
- **Durable Medical Equipment**
- **Home Health Care;**
- **Home Infusion Therapy;**
- **Outpatient Procedures not performed in the office; and**
- **Prosthetics and Orthotics**
- **Oral Pharnyx Procedures**
- **Experimental/investigational/unproven procedures**
- **Sleep management procedures**
- **Spinal procedures**

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

The following information will be requested as part of the precertification process:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the Plan Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The Plan of Care, treatment protocol and/or informed consent, if applicable

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

Non-Preferred Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore pre-certification should be obtained.

Obtaining pre-certification will determine the number of days of non-Preferred Hospital confinement or use of other listed medical services authorized for payment. **Failure to obtain pre-certification is a denial of coverage.**

Obtaining pre-certification or pre-notification of a particular service does not guarantee that a claim will be reimbursed by the Plan. Benefit payments are subject to the eligibility and other terms, conditions, limitations and exclusions of the Plan at the time services are provided.

If a pre-certification request is denied, the Plan Participant may appeal that determination. Please refer to the Internal and External Claims Review Procedures section for more information.

Please note that Preferred Providers who fail to obtain pre-certification for services listed above will not be paid for those services and cannot bill the Plan Participant in accordance with the contractual obligation with the Cigna® *network.*

All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A Cigna® nurse will contact the Plan Participant to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan and post-discharge follow-up.

PRE-NOTIFICATION OF SERVICES

(Applies to certain services other than those for which pre-certification is required.)
Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. A benefit determination on a claim will be made only after the claim has been submitted. A pre-notification of services by is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in this Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures section.

All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within 15 days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Plan Participant or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Plan Participant will be provided notice of the Plan's determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

As a reminder, a pre-notification of services by Cigna® Management is not a determination by the Plan that a claim will be paid.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within 30 days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Participant disagrees with the adverse pre-notification determination. The Plan Participant may include any additional documentation, medical records, and/or letters from the Plan Participant's treating Physician(s). The request for reconsideration should be addressed to:

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Plan Participant, and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the medical necessity, the Experimental/ Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within 30 days of the receipt of the request for reconsideration.

CASE MANAGEMENT

If a Plan Participant has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Plan Participant, and to work with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Plan Participant, the family, and the attending Physician in order to assist in coordinating the plan of care approved by the Plan Participant's attending Physician and the Plan Participant.

This plan of care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Plan Participant and family choose not to participate.

Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis.

Allowable Charge. Except as otherwise set forth herein, Allowable Charge means the amount for a treatment, service, or supply that is (a) the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement; or in the absence of any such arrangement, Allowable Charge means (b) Allowable Claims Limit as determined by the Claim Review and Audit Program.

In the event the Non-Preferred Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

Allowable Claim Limits means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of a covered Illness or Injury, but only to the extent that such fees are within the Allowable Claims Limit. Please refer to the section, "Claim Review and Audit Program" for additional information regarding Allowable Claim Limits.

Applied Behavioral Analysis, also known as Lovaas therapy, is therapy provided by an individual who is licensed by the behavior analyst certification board or is certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

For purposes of Applied Behavioral Analysis, care shall include Medically Necessary interactive therapies derived from evidence-based research, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

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

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

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Covered Charge means any Medically Necessary item of expense, for which the charge is reasonable and necessary, within Allowable Claim Limits, or is based on the contracted fee schedule of an alternate care delivery system. The Covered Charge will be determined by the Plan Administrator, in its sole discretion.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Direct Agreement means a complete agreement with a Directly Contracted Provider that contains the terms and conditions under which the Plan Participant may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for claims submitted by a Directly Contracted Provider.

Directly Contracted Provider means a medical provider which has entered into a Direct Agreement to provide certain medical services to Plan Participants at agreed upon Allowable Claim Limits.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means the following:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and

(2) Within the capabilities of the staff and facilities available at the Hospital (including Hospital outpatient department that provides Emergency Services) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment (as are required under section 1867 of the Social Security Act 42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to a Medical Emergency, Emergency Services shall also include an item or service provided by a Non-Preferred Provider (regardless of the department of the Hospital in which items or services are furnished) after the Plan Participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Plan Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Preferred Provider.

Employee means a person who is classified by his Employer as an Active, common law employee.

Employer is Centenary College of Louisiana.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the Plan Participant informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Facility means a healthcare institution which meets all applicable state or local licensure requirements. For the purposes of the Claim Review and Audit Program, Facility includes, but is not limited to, Hospitals, emergency, rehabilitation and Skilled Nursing Facilities, Outpatient Surgical Centers, laboratories, x-ray, MRI or other CT Facilities, and any other health care Facility.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective

therapeutic drugs specifically covered by this Plan.

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the Plan Participant's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; and it must specify the type and extent of Home Health Care required for the treatment of the Plan Participant.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

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

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

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

Hospital is an institution that is engaged primarily in providing medical care and treatment of sick and Injured persons on an inpatient basis at the Plan Participant's expense and that fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

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

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

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

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of Plan Participants who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the initial period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the Plan Participant's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the Plan Participant or provider of medical services; and is the most appropriate level of services which can be safely provided to the Plan Participant.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a BMI (Body Mass Index) of 40+. The BMI is a factor produced by dividing a person's weight (in kilograms) by his/her height squared (in meters).

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

Non-Preferred Provider/Non-Preferred Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the Plan Participant's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Outpatient Hospital Services is medical care or treatment that does not require an overnight stay in a hospital or medical facility.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Certified Nurse Midwife (CNM) or Certified Midwife (CM), Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Centenary College of Louisiana Group Benefit Plan, which is a benefits plan for certain Employees of Centenary College of Louisiana and is described in this document.

Plan of Care is a written plan that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or

treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Preferred Provider/Preferred Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Primary Care Visits are visits with a Primary Care Physician for the purposes of supervising, coordinating, and providing initial care and basic medical services to Plan Participants and maintaining continuity of patient care.

Qualifying Payment Amount (QPA) means the median of the contracted rates recognized by the Plan or recognized by all Plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a QPA, said amount will be determined by referencing an applicable state all-payer claims database or any eligible third-party database in accordance with applicable law.

Recognized Amount, except for Non-Preferred Provider air ambulance services, means an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable, and for Non-Preferred Provider air ambulance services, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

Retired Employee/Retiree is one who has terminated employment and whose age plus years of full-time continuous service at Centenary College of Louisiana equal 75, with a minimum of ten years full-time service to the Employer.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore Plan Participants to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each Plan Participant.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

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

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco/nicotine and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy. This includes Dependent daughters.

(2) **Alternative medicine.** Services include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, massage therapy and rolfing, and naturopathic care.

This exclusion does not include a Naturopathic Doctor (N.D.), for care, treatment, or services performed within the scope of his/her license, otherwise described as a Covered Charge under this Plan.

(3) **Biofeedback**. Charges in connection with biofeedback.

(4) **Coding Guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect at the time services were received.

(5) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under this Plan.

(6) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental Anomalies, or previous covered therapeutic processes.

(7) **Counseling.** Care and treatment for marital and pre-marital counseling.

(8) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board.

(9) **Dental Care.** Care, treatment, services and supplies including appliances in connection with dental services including methods of treatment to alter vertical dimension, malocclusion, hyperplasia or hypoplasia of the mandibular and/or maxilla except as specifically stated as a benefit under this Plan.

(10) **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a benefit under this Plan.

(11) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

(12) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan or as specifically stated as a benefit under this Plan.

(13) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/ Investigational or not Medically Necessary.

(14) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(15) Routine **foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) except as specifically stated as a benefit under this Plan.

(16) **Foreign travel.** Care, treatment, or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(17) **Genetic testing.** Charges related to genetic testing performed as a diagnostic tool to predict the presence of a specific disease in those with a familial history, preconception or prenatal screening or population screening unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(19) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician except for wigs after chemotherapy or radiation treatment.

(20) **Hearing aids and exams.** Charges for exams for the purpose of prescribing and fitting of hearing aids and services or supplies in connection with diagnosing and treating hearing loss.

(21) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(22) **Illegal acts.** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs or a combination thereof, or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer's determination of inebriation will be sufficient for this exclusion. It is not necessary for this exclusion to apply that criminal charges be filed, or if filed, that a conviction result. Expenses will be covered for injured

Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(23) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence or sexual dysfunction.

(24) **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.

(25) **Infertility.** Charges for services to restore or enhance fertility, including, but not limited to, artificial insemination, in vitro fertilization, embryo transfer procedures and sterilization reversal. Services for the diagnosis only of Infertility will be considered a Covered Charge.

(26) **Mailing and Sales Tax.** Charges for mailing, shipping, handling, postage, conveyance, and sales tax.

(27) **Missed Appointment.** Charges for failure to keep a scheduled visit or appointment.

(28) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(29) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(30) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(31) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(32) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(33) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness, except as specifically stated as a benefit under this Plan. Panniculectomy is not a covered under this Plan.

(34) **Occupational Injury**. Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:

- Has waived his/her rights to Workers' Compensation benefits;
- Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits; or
- The Plan Participant is permitted to elect not to be covered under Workers' Compensation and has affirmatively made that election.

(35) **Orthognathic Surgery**. Charges for any orthognathic condition.

(36) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(37) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(38) **Pregnancy of Dependent other than Spouse.** Care and treatment of Pregnancy and Complications of Pregnancy for a covered Dependent other than a covered Spouse, except as specifically stated as a benefit under this Plan.

(39) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(40) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

(41) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(42) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(43) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(44) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(45) **Surrogacy**. Prenatal, delivery and postnatal services for a surrogate who is not a Plan Participant.

(46) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.

(47) **War.** Any loss that is due to a declared or undeclared act of war.

Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

PRESCRIPTION DRUG BENEFITS

The Coordination of Benefits provision will not apply to Prescription Drugs purchased at a Participating Pharmacy.

PREFERRED RETAIL PHARMACY

Participating Pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. ***Veracity Rx powered by ProCare Rx*** is the administrator of the Pharmacy drug plan.

The Prescription Drug copayment amount as shown in the Prescription Drug Schedule of Benefits is applied to each covered retail pharmacy drug charge. Prescription Drug expenses apply to the maximum out-of-pocket amount as stated in the Schedule of Benefits.

Any one retail Pharmacy prescription is limited to a 34-day supply.

If a drug is purchased from a non-Participating Pharmacy, or a Participating Pharmacy when the Plan Participant's ID card is not used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to ***Veracity Rx*** for reimbursement (less applicable copayments and medical deductible as shown in the Schedule of Benefits section). Prescription Drug expenses obtained through a Non-Participating Pharmacy *will not apply* to the maximum out-of-pocket amount as stated in the Schedule of Benefits.

NON-PREFERRED PHARMACIES

Non-Preferred Pharmacies include Target, Walmart, Sam's Club, CVS, Rite-Aid and Walgreens.

STEP THERAPY PROGRAM

Step Therapy is a process that requires the use of one or more first line agents before a medication which is part of a step therapy protocol can be utilized.

The goal of step therapy is to ensure that safe and cost effective medications are used, based on recognized treatment guidelines and well documented clinical studies. This means that in some instances the Plan Participant will need to try one or more medications which are considered first line before he/she is able to receive a "second step" medication through his/her pharmacy benefit plan.

For a complete list of medications that are subject to Step Therapy protocols, contact **Veracity Rx** at (888) 388-8228.

Covered Prescription Drugs

Note: Some quantity limitations and/or prior authorization may apply.

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law, excluding any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other injectable diabetic medications and the following diabetic supplies, when prescribed by a Physician: lancets, lancet devices, alcohol swabs, blood glucose meters, blood glucose and test strips, blood test strips, insulin pump supplies (not including the insulin pump) and insulin syringes and needles.

(4) Self injectables.

(5) Acne medications, when prescribed by a Physician. A prior authorization is required for Plan Participants ages 27 years and over.

The following will be covered at 100 %, no copayment required for formulary drugs.

Benefits may be subject to prescription formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Schedule of Benefits. ***Contact Veracity Rx at (888) 388-8228 to request coverage of the medication as a non-formulary medical exception.***

(1) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

(2) Physician-prescribed tobacco/nicotine cessation products. Physician-prescribed tobacco/nicotine replacement products (nicotine patch, gum, lozenges) and Physician-prescribed medications (such as Zyban, Chantix (and subject to change)).

(3) Certain vaccinations/immunizations as recommended by applicable federal law will be covered only when rendered through a Participating Pharmacy. Please note: Not all Participating Pharmacies may be providing vaccinations/immunizations or may vary in what they offer. It is important to check with the Participating Pharmacy to determine availability, age restrictions, any prescription requirements or hours of service. *Please contact* **Veracity Rx** at (888) 388-8228 *for more information regarding this benefit.*

(4) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact *Veracity Rx at* (888) 388-8228 for more information regarding which medications are available. Note: Age and/or quantity limitations may apply:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

Limits To This Benefit

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan when deemed Medically Necessary.*

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(9) **Immunization.** Immunization agents or biological sera, except as specifically stated as a benefit under this Plan.

(10) **Infertility.** A charge for Infertility medication.

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(15) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin, diabetic supplies or to over-the-counter drugs that are prescribed by a Physician.

(16) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(17) **Specialty and Mail Order Prescriptions.**

HOW TO SUBMIT PHARMACY CLAIMS

For prescription claims questions or to obtain a claim form please call:
Veracity Rx at (888) 388-8228
access their website at:
https://veracity.procarerx.com
Email for assistance to: help@veracity-rx.com

Please submit Prescription Drug claim forms to:

ProCare Rx
1267 Professional Parkway
Gainesville, Georgia 30507

Or fax ALL information to (678) 281-7587.

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her EBMS/**Centenary College of Louisiana Group Benefit Plan** identification card to the provider. Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**Centenary College of Louisiana Group Benefit Plan,** Group #00533)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at http://www.ebms.com.

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the Claims Administrator at the applicable address below:

PREFERRED PROVIDERS:
Cigna
P.O. Box 188061
Chattanooga, TN 37422-8061
(866) 326-7849

NON-PREFERRED PROVIDERS:
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain

services is strongly recommended, but not required by the Plan. A pre-notification of services is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits and cannot be appealed under this section. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of claims:

Concurrent Care Determination

> A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.*

Post-Service Claim

> A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment. Full and final authority to adjudicate Claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make Claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and applicable law.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45-day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information. Under the No Surprises Act, the Plan will have up to 30 calendar days to send a notice of denial of payment or an initial payment to the Non-Preferred Provider from the time the Claim is resubmitted with additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination

that will include the following:

(1) Information to identify the claim involved.

(2) Specific reason(s) for the denial, including the denial code and its meaning.

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

(4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available internal and external review procedures.

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

If applicable:

(7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

(9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively or is a retroactive cancellation or discontinuance because of the Plan Participant's failure to timely pay required premiums.

Claims Review Procedure – General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Note: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Non-Preferred Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a Non-Preferred Provider's payment dispute through the IDR process.

Internal Appeal Procedure

First Level of Internal Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, Montana 59104

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The First Level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Second Level of Internal Review

If the Claimant does not agree with the determination from the First Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Plan Administrator
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, Montana 59104

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above. All decision-making and discretionary authority to make appeal determinations lies with the Plan Administrator; however, the Plan Administrator may delegate to the Claims Administrator responsibility to process appeals in accordance with the terms of the Plan and the Plan Administrator's direction.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review.

External Review Procedure

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four months from the date of receipt of the notice of the final internal adverse benefit determination or the first day of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or service is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Violation of cost-sharing and surprise billings protections as identified within the NSA.
- Application of treatment limits to a Claim for a Mental Disorder.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within six business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four-month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. ***Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.***

PROVIDER OF SERVICE APPEAL RIGHTS - CLAIM REVIEW AND AUDIT PROGRAM

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal, and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Internal and External Claims Review Procedures" above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Charges directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Internal and External Claims Review Procedures" above.**

For purposes of this section, the provider's waiver to pursue Covered Charges does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB04 or on a CMS – 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeal rights.

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

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

(1) Group or nongroup insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and nongroup coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

(7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

(8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Defined Terms section.)

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Plan Participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Plan Participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(B) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

(1) The benefits of the plan which covers the person directly (that is, as a Plan Participant/Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B"). For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

(2) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, the plan of that parent's spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

1st The plan covering the custodial parent,
2nd The plan covering the spouse of the custodial parent,
3rd The plan covering the non-custodial parent, and
4th The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (5) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

(3) The benefits of a benefit plan which covers a person as a covered Employee who is neither laid off nor retired or as a Dependent of a covered Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Plan Participant. This rule does not apply if Rule (1) can be used to determine the order of benefits If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(4) The benefits of a benefit plan which covers a person as a covered Employee who is neither laid off nor retired or a Dependent of a covered Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.

(5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the Plan Participant for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or

obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

THIRD PARTY RECOVERY PROVISION

By enrollment in the Plan, a Plan Participant agrees to the provisions of this Section as a condition precedent to receiving benefits under this Plan. If the Plan Participant fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Defined Terms

"Plan Participant" means anyone covered under the Plan, including but not limited to minor dependents and deceased Plan Participants. Plan Participant shall include the parents, trustee, guardian, heir, personal representative or other representative of a Plan Participant, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Illness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Plan Participant's rights to Recover or pursue Recovery from a Third Party who is liable to the Plan Participant for expenses for which the Plan has paid or may agree to pay benefits.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Right to Reimbursement

This provision applies when the Plan Participant incurs medical or dental expenses due to an Injury, Illness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Plan Participant may have a claim against a Third Party for payment of such expenses. To the extent the Plan paid benefits on the Plan Participant's behalf, the Plan Participant agrees that the Plan has an equitable lien on any Recovery whether or not such Recovery(s) is designated as payment for such expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Participant, and/or anyone on his or her behalf, agrees to hold in trust for the benefit of the Plan, that portion of any Recovery received or that may be received from a Third Party and to which the Plan is entitled for reimbursement of benefits paid by the Plan on the Plan Participant's behalf. The Plan Participant shall promptly reimburse the Plan out of such Recovery, in first priority for the full amount of the Plan's lien. The Plan Participant will reimburse the Plan first, even if the Plan Participant has not been fully compensated or "made whole" and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses.

The Plan will not pay or be responsible for attorney fees and/or costs of recovery associated with a Plan Participant pursuing a claim against a Third Party, unless the Plan agrees in writing to such a reduction in its equitable lien, or subject to the terms of a court order.

Right to Subrogation

This provision applies when the Plan Participant incurs medical or dental expenses due to an Injury, Illness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Plan Participant may have a claim against a Third Party

for payment of such expenses.

The Plan Participant agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Plan Participant may have now or in the future against a Third Party who has or may have caused, contributed, aggravated, and/or been responsible for the Plan Participant's Injury, Illness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits. The Plan Participant further agrees that the Plan is subrogated to any and all claims or rights that the Plan Participant may have against any Recovery, including the Plan Participant's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Plan Participant. The Plan is not obligated to pursue this right independently or on behalf of the Plan Participant, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Plan Participant automatically assigns to the Plan any and all rights he or she has or may have against any Third Party to the full extent of the Plan's equitable lien. The Plan Participant agrees to:

(1) Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;

(2) Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;

(3) Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Plan Participant's Injury, Illness, condition, and/or accident, including any efforts by another individual to Recover on the Plan Participant's behalf;

(4) Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;

(5) Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Plan Participant's Injury, Illness, condition, and/or accident;

(6) Hold in trust that portion of any Recovery received by the Plan Participant or on the Plan Participant's behalf equal to the Plan's equitable lien until such time as the Plan is repaid in full;

(7) Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and

(8) Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

(1) The Plan may require the Plan Participant as a condition of paying benefits for the Plan Participant's Injury, Illness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;

(2) The Plan may withhold payment of benefits to the extent of any Recovery received by or on behalf of a Plan Participant;

(3) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Plan Participant;

(4) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible; or

(5) The Plan may, to the extent of any benefits paid by the Plan which have not otherwise been reimbursed to the Plan, offset any future benefits otherwise payable under the Plan to the Plan Participant or on the Plan Participant's behalf.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedures as deemed necessary and appropriate to administrate the Plan's rights under this section.

Right to Recover Benefits Paid in Error

The Plan has the right to recover any benefits the Plan paid in error to the Plan Participant or on behalf of a Plan Participant to which the Plan Participant is not entitled, for services which were not covered under the Plan, or for benefits paid in excess of the Plan's Allowable Charges. The Plan may recover benefits paid in error from the Plan Participant, the provider who received a payment from the Plan on the Plan Participant's behalf, or from any person who may have benefited. The Plan may also offset any future benefits otherwise payable to or on the Plan Participant's behalf, or from any other Plan Participant enrolled through the same covered Employee.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

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

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. Domestic Partners do not qualify for COBRA Continuance Coverage.

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104
(318) 869-5191

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

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

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation

Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination of employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18-month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

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

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104
(318) 869-5191

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104
(318) 869-5191

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage will end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

PLAN ADMINISTRATOR:
Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104
(318) 869-5191

COBRA ADMINISTRATOR:
Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(800) 777-3575 or (406) 245-3575

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Centenary College of Louisiana Group Benefit Plan is the benefit plan of Centenary College of Louisiana, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Centenary College of Louisiana to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Centenary College of Louisiana shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect

amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Centenary College of Louisiana, shall direct the disposition of Plan assets, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

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

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

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

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Director of Human Resources

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

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

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

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(c) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(d) Report to the Plan any security incident of which it becomes aware.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

- Review this Summary Plan Description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Centenary College of Louisiana Group Benefit Plan

TAX ID NUMBER: 72-0408915

PLAN NUMBER: 501

PLAN EFFECTIVE DATE: January 1, 2016

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104
(318) 869-5191

PLAN ADMINISTRATOR

Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104
(318) 869-5191

NAMED FIDUCIARY

Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104

AGENT FOR SERVICE OF LEGAL PROCESS

Centenary College of Louisiana
2911 Centenary Blvd
Shreveport, LA 71104

Service of process may also be made on the Plan Administrator.

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(800) 777-3575 or (406) 245-3575

Plan Name: Centenary College of Louisiana Group Benefit Plan

Effective: January 1, 2016

Restatement: January 1, 2022

I, Robert Blue, certify that I am the Vice President for F&A

Name Title

of the Plan Administrator for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms described herein and am hereby authorizing the implementation of the restated Plan as of the restatement date noted above.

Signature: DocuSigned by: Robert Blue D6BFDAAADEC8438...

Print Name: Robert Blue

Date: 4/8/2022