UnitedHealthcare Insurance Company

Group Policy

For

Central Community School District

Enrolling Group Number: 905655

Policy Effective Date: September 1, 2015

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 60 days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

3.4 Payment of the Policy Charge

The Policy Charge is payable to us in advance by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

3.5 Grace Period

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

C. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation or contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

   - The effective date of this Policy.
   - The date of the act, practice or omission, if later.

E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

6.2 Dispute Resolution

Parties are encouraged to attempt, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it may submit the decision, complaint or dispute to arbitration pursuant to the rules of the *American Arbitration Association*.

Arbitration will take place in Hartford County, Connecticut.

The matter must be submitted to arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by controlling law.

This Arbitration process is invoked at the request of the Enrolling Group. Arbitration is not binding and does not deprive the courts of jurisdiction. The Enrolling Group does not forfeit any right to seek judicial resolution of the dispute as a result of arbitration.

6.3 Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of three years.

6.4 Amendments and Alterations

Amendments to this Policy are effective 60 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Other than changes to Exhibit 2 stated in a Notice of Change to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.6 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.8 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

6.9 Examination of Covered Persons

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

6.10 Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

6.11 Workers' Compensation Not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.12 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.13 Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.14 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

6.15 Certification of Coverage Forms

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.16 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*,

and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at www.myuhc.com.

6.17 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

Exhibit 1

1. **Parties**. The parties to this Policy are UnitedHealthcare Insurance Company and Central Community School District, the Enrolling Group.

2. **Effective Date of this Policy**. The effective date of this Policy is 12:01 a.m. on September 1, 2015 in the time zone of the Enrolling Group's location.

3. **Place of Issuance**. We are delivering this Policy in the State of Louisiana. This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of Louisiana are the laws that govern this Policy.

4. **Premiums**. We reserve the right to change the *Schedule of Premium Rates* specified in each Exhibit 2, after a 45-day prior written notice after the Policy has been in effect for 12 months and then not more often than every 6 months thereafter, or on any date the provisions of this Policy are amended. We also reserve the right to change the Schedule of Premium Rates retroactive to the effective date, if a Material Misrepresentation has resulted in a lower schedule of rates.

5. **Computation of Policy Charge**. A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.

6. **Payment of the Policy Charge**. The Policy Charge is payable to us in advance by the Enrolling Group on a monthly basis.

7. **Minimum Participation Requirement**. The minimum participation requirement for the Enrolling Group is 75% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.

8. **Minimum Contribution Requirement**. The Minimum Contribution Requirement does not apply.

9. **Notice**. Any notice sent to us under this Policy must be addressed to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Enrolling Group under this Policy must be addressed to:

   Central Community School District

   10510 Joor Road

   Central, Louisiana 70818

10. 905655: Enrolling Group Number

Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plus (HSA) Plan 4TX.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      1st of the month, on or following, 1 month of full time employment

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is September 1, 2015.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the last day of the required waiting period. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of September 1, 2015 is shown below:

Coverage Classification	**Monthly Premium**
Employee Only	$481.67
Employee plus Spouse	$963.35
Employee plus Child(ren)	$891.09
Employee plus Family	$1,372.76
Without Medicare Retiree	$481.67
Medicare Retiree	$385.34
One With Medicare and One Without Medicare	$867.01
Two Without Medicare	$963.35
Two With Medicare	$770.91
One Without Medicare and Dependent	$891.09
One With Medicare and Dependent	$795.02
One Without Medicare and Dependent with Medicare	$850.39
One With Medicare, Dependent with Medicare	$713.09
Two Without Medicare - Family Coverage	$1,372.76

One With Medicare and One Without Medicare - Family Coverage	$1,276.84
Two Without Medicare, Dependent with Medicare	$1,332.22
Two With Medicare, Family Coverage	$1,180.45
One With Medicare and One Without Medicare, Dependent with Medicare	$1235.59
Two With Medicare , Dependent with Medicare	$1,098.53

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plus Plan #424.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      1st of the month, on or following, 1 month of full time employment

3. **Open Enrollment Period**. An Open Enrollment Period of at least 31 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is September 1, 2015.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the last day of the required waiting period. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of September 1, 2015 is shown below:

Coverage Classification	**Monthly Premium**
Employee Only	$558.18
Employee plus Spouse	$1,116.37
Employee plus Child(ren)	$1,032.63
Employee plus Family	$1,590.82
Without Medicare Retiree	$558.18
Medicare Retiree	$446.54
One With Medicare and One Without Medicare	$1,004.72
Two Without Medicare	$1,116.37
Two With Medicare	$893.37
One Without Medicare and Dependent	$1,032.63
One With Medicare and Dependent	$921.31
One Without Medicare and Dependent with Medicare	$985.47
One With Medicare, Dependent with Medicare	$826.36
Two Without Medicare - Family Coverage	$1,590.82

One With Medicare and One Without Medicare - Family Coverage	$1,479.65
Two Without Medicare, Dependent with Medicare	$1,543.83
Two With Medicare, Family Coverage	$1,367.95
One With Medicare and One Without Medicare, Dependent with Medicare	$1,431.85
Two With Medicare , Dependent with Medicare	$1,273.03

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plus Plan 98Q.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      1st of the month, on or following, 1 month of full time employment

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is September 1, 2015.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the last day of the required waiting period. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of September 1, 2015 is shown below:

Coverage Classification	**Monthly Premium**
Employee Only	$555.86
Employee plus Spouse	$1,111.73
Employee plus Child(ren)	$1,028.34
Employee plus Family	$1,584.21
Without Medicare Retiree	$555.86
Medicare Retiree	$444.69
One With Medicare and One Without Medicare	$1,000.55
Two Without Medicare	$1,111.73
Two With Medicare	$889.65
One Without Medicare and Dependent	$1,028.34
One With Medicare and Dependent	$917.48
One Without Medicare and Dependent with Medicare	$981.38
One With Medicare, Dependent with Medicare	$822.92
Two Without Medicare - Family Coverage	$1,584.21

One With Medicare and One Without Medicare - Family Coverage	$1,473.50
Two Without Medicare, Dependent with Medicare	$1,537.42
Two With Medicare, Family Coverage	$1,362.27
One With Medicare and One Without Medicare, Dependent with Medicare	$1,425.90
Two With Medicare , Dependent with Medicare	$1,267.74

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 3 - SimplyEngaged®

The Enrolling Group agrees to implement a wellness program that rewards Subscribers and Enrolled Dependent spouses with incentives for completing certain wellness criteria, as determined by us.

The Enrolling Group further agrees to implement at least the following program requirements:

- Provide an announcement letter sent to all the Enrolling Group's employees from the Enrolling Group's owner or a senior executive, promoting the incentive program.
- Sponsor at least one health fair/wellness event within the first 120 days, or later based on our discretion, of the Policy year (including a biometric screening), making commercially reasonable effort to encourage attendance. The biometric screening event must be held the same day as the health/wellness event during standard hours for screening events, which are Monday through Friday, 5:00 a.m. to 7:00 p.m., EST. After receiving at least 60 days prior written notice for event implementing, we will cover the cost of a single biometric screening, per event, per year, for each Subscriber and Enrolled Dependent spouse participating in such screenings at the Enrolling Group's fair/wellness event. If less than 20 individuals participate in such biometric screening, we may impose an additional fee on Enrolling Group.
- Provide information necessary to facilitate promotional activities.

The Enrolling Group agrees it will meet formally two times per year with its broker and our representative. These meetings will be with the Enrolling Group's owner or a senior executive of the Enrolling Group. The first meeting must occur early in the Policy year to address the details of implementing the Enrolling Group's obligation as described in this Exhibit. The second meeting must occur at least 120 days, or later based on our discretion, prior to the anniversary date of the Policy.

Enrolling Group acknowledges incentives can only be earned by Subscribers and Enrolled Dependent spouses once during an incentive period. For example, if a health assessment is completed on February 1, 2014, when the incentive period begins January 1, 2014 and the Subscriber or Enrolled Dependent spouse receives an incentive, the Subscriber or Enrolled Dependent spouse will not become eligible to earn an additional incentive for completion of a new health assessment until January 1, 2015.

Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the *Louisiana Life and Health Insurance Guaranty Association*. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY*. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

- Insurance companies and insurance agents are prohibited by law from using the existence of the Guaranty Association or its coverage to sell you an insurance policy.
- You should not rely on the availability of coverage under the Guaranty Association when selecting an insurer.
- The Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

Louisiana Life and Health Insurance Guaranty Association (LLHIGA)

PO Drawer 44126

Baton Rouge, LA 70804

Louisiana Department of Insurance

PO Box 94214

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The state law that provides for this safety-net coverage is called the *Louisiana Life and Health Insurance Guaranty Association Law*. The following is a brief summary of this Law's coverages, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of the Guaranty Association.

Coverage

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); or
- unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under section 403(b) of the Internal Revenue Code, except that, even if qualified under section 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- any obligation that does not arise under the express written terms of the policy or contract;
- any policy or contract providing any hospital, medical, prescription drug or other health care benefit pursuant to Medicare part C or part D coverage.
- Other exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Law, Louisiana Revised Statutes R.S. 22:2081 *et seq*.

Limits on Amount of Coverage

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $500,000 limit, the Association will not pay more than $100,000 in cash surrender values, $500,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.