Ameritas

Ameritas Life Insurance Corp.
5900 O Street / P.O. Box 81889 / Lincoln, NE 68501-1889
Claims Only 800-487-5553 / Administration & Billing 800-659-2223
Fax 402-467-7338

STATEMENT OF PREMIUMS FOR COVERAGE FROM:
09-01-2020 THROUGH 09-30-2020

PREVIOUS AMOUNT DUE	239.52
PAYMENT RECEIVED PRIOR 08-17-2020 THANK YOU!	119.76

CURRENT MONTH'S PREMIUM

PLEASE NOTE LAST DAY WORKED OR
TYPE OF COVERAGE CHANGE AND
EFFECTIVE DATE (IF APPLICABLE).

CERT #	NAME	CLASS DEP	EE-	PREMIUMS 3 DEP-	TOTAL
5	DAVIS,LAUREN	01A		36.32	36.32
4	SMITH,SARA	01A		36.32	36.32
3	TEXADA,COURTNEY A	01A		36.32	36.32
				PREMIUM TOTAL:	108.96

ADJUSTMENTS

CERT #	NAME	DATE	MO	TYPE		TOTAL
	ADMINISTRATION FEE	092020	1	OTHER		15.00
					ADJUSTMENT TOTAL:	15.00
					TOTAL DUE:	243.72

Removed Sara Smith this payment.

0 01052163600001 00000024372

Ameritas Life Insurance Corp.
5900 O Street / P.O. Box 81889 / Lincoln, NE 68501-1889
Claims Only 800-487-5553 / Administration & Billing 800-659-2223
Fax 402-467-7338

STATEMENT OF PREMIUMS FOR COVERAGE FROM:
09-01-2020 THROUGH 09-30-2020

PREVIOUS AMOUNT DUE	70.56
PAYMENT RECEIVED PRIOR 08-17-2020 THANK YOU!	35.28

CURRENT MONTH'S PREMIUM

PLEASE NOTE LAST DAY WORKED OR
TYPE OF COVERAGE CHANGE AND
EFFECTIVE DATE (IF APPLICABLE).

CERT #	NAME	CLASS DEP	EE-	PREMIUMS 3 DEP-	TOTAL
4	DAVIS,LAUREN	O2A		12.80	12.80
3	LOYD,DE ETTE M	O2A		12.80	12.80
8	SMITH,SARA	O2A		12.80	12.80
				PREMIUM TOTAL:	38.40
				TOTAL DUE:	73.68

0 010521636000002 0000000736

Ameritas

Ameritas Life Insurance Corp.

PO BOX 81889 / LINCOLN NE 68501-1889
800-659-2223

September 1, 2020

Address Service Requested . .

0187 000804

UNIVERSITY ACADEMY
DE ETTE LOYD
141 MIDDLETON DR
ALEXANDRIA, LA 71302-9322

AMENDMENT RIDER

To be attached to and made a part of Group Policy Number 010-521636.

Issued to UNIVERSITY ACADEMY

It is hereby agreed that this policy is amended as follows:

1) The section entitled "TABLE OF MONTHLY PREMIUM RATES", on 9050 is deleted and the following is substituted:

Table of Monthly Premium Rates

CLASS 01

Dental Care Insurance

$36.32	per Insured Person
$36.00	Spouse Only
$46.40	Child(ren) Only
$82.40	Spouse and Child(ren)

CLASS 02

Eye Care Insurance

$12.80	per Insured Person
$14.96	Spouse Only
$9.60	Child(ren) Only
$24.56	Spouse and Child(ren)

This Amendment Rider is effective September 1, 2020. Please verify the rates and place the rider with your Group Policy. A copy of this correspondence is being sent to the Policyholder, Broker, and appropriate Group Office.

0187245100080401

GUIDEONE™
INSURANCE
1111 Ashworth Road, West Des Moines, Iowa 50265-3538

GuideOne Mutual Insurance Company
GuideOne Elite Insurance Company
GuideOne Specialty Mutual Insurance Company
GuideOne America Insurance Company

ACCOUNT NUMBER 006113464-01

AGENT: 17-016
BROWN & BROWN OF BATON ROUGE
6300 CORPORATE BLVD STE 250
BATON ROUGE, LA 70809

AGENT PHONE 225-763-5600

(PREMIUM PAID BY)

000491-1144 g1bl04_13210
UNIVERSITY ACADEMY OF CENTRAL LOUISIANA
141 MIDDLETON DR
ALEXANDRIA LA 71302-9322

PREMIUM STATEMENT

POLICY NUMBER	POLICIES IN THIS ACCOUNT WITH AN AMOUNT DUE POLICY TYPE	POLICY TERM	MINIMUM DUE	CURRENT BALANCE
001783216	BUSINESS AUTO	08/01/19 TO 08/01/20	$810.00	$810.00

Thank you for choosing GuideOne Insurance. You have selected the convenient four-payment plan, which includes a small installment fee.

We appreciate your prompt payment. Payments received before the due date will keep your account current and prevent a late charge. If you have any questions about your policy, please contact your agent listed above.

Again, thank you for the opportunity to continue serving your insurance needs.

(SEE PAGE 2 FOR IMPORTANT BILLING INFORMATION)

USCL40

CURRENT BALANCE	$810.00	MINIMUM DUE	$810.00	DUE DATE	05/02/20

ORIGINAL COPY

040120

GUIDEONE™
INSURANCE
1111 Ashworth Road, West Des Moines, Iowa 50265-3538

GuideOne Mutual Insurance Company
GuideOne Elite Insurance Company
GuideOne Specialty Mutual Insurance Company
GuideOne America Insurance Company

ACCOUNT NUMBER 006113464-01

AGENT: 17-016
BROWN & BROWN OF BATON ROUGE
6300 CORPORATE BLVD STE 250
BATON ROUGE, LA 70809

AGENT PHONE 225-763-5600

(PREMIUM PAID BY)

000156-332 g1bl04_14335_UB60INL
UNIVERSITY ACADEMY OF CENTRAL LOUISIANA
141 MIDDLETON DR
ALEXANDRIA LA 71302-9322

RAL

PREMIUM STATEMENT

POLICY NUMBER	POLICIES IN THIS ACCOUNT WITH AN AMOUNT DUE POLICY TYPE	POLICY TERM	MINIMUM DUE	CURRENT BALANCE
001432029	COMMERCIAL MONOLINE	08/01/20 TO 08/01/21	$1,163.25	$4,653.00
~~001432031~~	~~WORKERS COMPENSATION~~	~~08/01/20 TO 08/01/21~~	~~$1,085.50~~	~~$4,343.00~~
001783216	BUSINESS AUTO	08/01/20 TO 08/01/21	$1,448.50	$5,794.00

Thank you for choosing GuideOne Insurance. You have selected the convenient four-payment plan, which includes a small installment fee.

We appreciate your prompt payment. Payments received before the due date will keep your account current and prevent a late charge. If you have any questions about your policy, please contact your agent listed above.

Again, thank you for the opportunity to continue serving your insurance needs.

(SEE PAGE 2 FOR IMPORTANT BILLING INFORMATION)

UBCL40

CURRENT BALANCE	$14,789.00	MINIMUM DUE	$3,697.25	DUE DATE	08/08/20

ORIGINAL COPY

070820

VANTAGE HEALTH PLAN

130 DeSiard St, Suite 300
Monroe, LA 71201
(844) 833-7505
TTY (866) 524-5144

CONFIDENTIAL: Contains PHI *9/9/2020*

STATEMENT

STATEMENT #QMXPRM048478047

10/01/2020 - 10/31/2020

UNIVERSITY ACADEMY OF CENTRAL LA - OFF EXCH

Previous Balance	$5,679.51
Payments/Credits	$-3,978.02
Balance Forward	$1,701.49

New Charges	$3,889.72
Balance Due	**$5,591.21**

Please detach this section and send back with payment using the enclosed envelope

Notice

All "Balance Due" amounts are due on: **9/25/2020**

Any "Balance Forward" amounts shown are due now.

VANTAGE HEALTH PLAN
130 DESIARD ST., SUITE 300
MONROE, LA 71201

Apply payment to this account:
UNIVERSITY ACADEMY OF CENTRAL LA -

VANTAGE HEALTH PLAN
130 DeSiard St, Suite 300
Monroe, LA 71201
(844) 833-7505
TTY (866) 524-5144

CONFIDENTIAL: Contains PHI *9/9/2020*

STATEMENT

STATEMENT #QMXPRM048478047

10/01/2020 - 10/31/2020

UNIVERSITY ACADEMY OF CENTRAL LA - OFF EXCH

141 MIDDLETON DR

ALEXANDRIA, LA 71302

MEMBER ID	MEMBER NAME	PLAN DESCRIPTION	PERIOD	AMOUNT
15637356700	ARTIGUE, KELSIE E	Freedom	OCT 2020	$405.02
	ARTIGUE, KELSIE E	Premium Adjustment	SEP 2020	$405.02
15635707500	DAVIS, LAUREN A	Freedom	OCT 2020	$459.70
15635707501	DAVIS, CHLOE GRACE	Freedom	OCT 2020	$309.84
	ELLISON, LEAH M	Premium Adjustment	SEP 2020	-$763.06
15637356200	GALLOW, JOSEPH	Freedom	OCT 2020	$459.70
	GALLOW, JOSEPH	Premium Adjustment	SEP 2020	$459.70
	HENRY, MARQUETTIEA	Premium Adjustment	SEP 2020	-$498.17
15637356300	JANZEN, JULIE C	Freedom	OCT 2020	$459.70
	JANZEN, JULIE C	Premium Adjustment	SEP 2020	$459.70
15637356100	JONES, MCKENZIE R	Freedom	OCT 2020	$405.02
	JONES, MCKENZIE R	Premium Adjustment	SEP 2020	$405.02
15632119900	LEBOEUF, COURTNEY TEXADA	Freedom	OCT 2020	$485.21
15637356000	MORGAN, JAMES B	Freedom	OCT 2020	$469.42
15637356001	MORGAN, LAUREN PAIGE	Freedom	OCT 2020	$440.26
15637356002	MORGAN, RYMAN THOMAS	Freedom	OCT 2020	$309.84
	MORGAN, JAMES B	Premium Adjustment	SEP 2020	$469.42
	MORGAN, LAUREN PAIGE	Premium Adjustment	SEP 2020	$440.26
	MORGAN, RYMAN THOMAS	Premium Adjustment	SEP 2020	$309.84
	SMITH, SARA M	Premium Adjustment	SEP 2020	-$440.26

New Charges	$5,451.18

VANTAGE HEALTH PLAN

130 DeSiard St, Suite 300
Monroe, LA 71201
(844) 833-7505
TTY (866) 524-5144

CONFIDENTIAL: Contains PHI *9/9/2020*

STATEMENT

STATEMENT #QMXPRM048475285

10/01/2020 - 10/31/2020

UNIVERSITY ACADEMY OF CENTRAL LA - OFF EXCH

141 MIDDLETON DR

ALEXANDRIA, LA 71302

MEMBER ID	MEMBER NAME	PLAN DESCRIPTION	PERIOD	AMOUNT
	ELLISON, LEAH M	Premium Adjustment	AUG 2020	-$701.56
	HENRY, MARQUETTIEA	Premium Adjustment	AUG 2020	-$462.91
	SMITH, SARA M	Premium Adjustment	AUG 2020	-$396.99

New Charges	$-1,561.46

Premium Statement

Billing Name: UNIVERSITY ACADEMY
Billing Number: 0423100-001 1
Due Date: 9/1/2020
Statement Date: 8/20/2020
Insuring Company: UNUM LIFE INSURANCE COMPANY OF AMERICA

Description		Amount
Long Term Disability (LTD)		$67.61
Lives:	15	
Coverage:	$42,258	
Monthly Rate:	.160 per $100	
Current Period Amount:		**$67.61**
Prior Period Amount Adjustment:		$0.00
Sub Total:		**$67.61**
Prior Total Amount Due:		$67.61
Amount Paid:		$67.61
Balance Forward:		$0.00
Total Amount Due:		**$67.61**

Payment Instructions:

1. Payment must be received on or before 9/1/2020.
2. Print Premium Statement.
3. Mail check with printed Premium Statement to:

UNUM LIFE INSURANCE COMPANY OF AMERICA
PO BOX 409548
ATLANTA, GA 30384-9548

Billing Period:
9/1/2020 - 9/30/2020

J1-12300 04 N

VANTAGE HEALTH PLAN

130 DeSiard St., Suite 300
Monroe, Louisiana 71201
318.361.0900

FREEDOM METAL PLAN

GROUP INSURANCE POLICY PROVIDING HEALTH BENEFITS

POLICYHOLDER:	University Academy of Central LA
PHYSICAL ADDRESS:	141 Middleton Dr Alexandria, LA 71302
POLICY ISSUE DATE:	September 1, 2018
MONTHLY PREMIUM DUE DATES:	1st Day of Each Month
POLICY ANNIVERSARY:	September 1, 2019

In consideration of the application and payment of the first premium,
VANTAGE HEALTH PLAN, INC. will pay benefits as provided and limited herein.

Vantage Health Plan, Inc.

MASTER GROUP CONTRACT

CONTRACT HOLDER: University Academy of Central LA

EFFECTIVE DATE: September 1, 2018

ANNIVERSARY DATE: September 1, 2019

This Master Group Contract (hereinafter referred to as "AGREEMENT") between Vantage Health Plan, Inc. (hereinafter referred to as "VANTAGE"), a Corporation organized and existing under the laws of the State of Louisiana, and University Academy of Central LA (hereinafter referred to as "EMPLOYER") shall become effective upon the Effective Date specified in the Group Enrollment Agreement and noted above.

WHEREAS, the primary purpose of VANTAGE is to arrange, manage and maintain a health care network to obtain quality, cost effective health care services from selected physicians, hospitals, and other providers and to market full risk HMO and other managed care products, and provide administrative services relative to the provision of such services to Employers and other entities that purchase, administer, or sponsor Group Health Plans for eligible Employees; and

WHEREAS, VANTAGE and EMPLOYER desire to enter into an AGREEMENT for VANTAGE to arrange for the provisions of health care services for EMPLOYER's eligible Employees; and

WHEREAS, VANTAGE issues this contract of VANTAGE benefits in consideration of any Addendum or Appendices and the Group Enrollment Agreement of the contract holder and of the payment of the subscription fees by the dates specified herein, and agrees to provide for the services and benefits as set forth in this AGREEMENT subject to all of its terms and provisions; and

WHEREAS, the subsequent pages form a part of this AGREEMENT as fully as if recited over the signatures affixed below.

NOW THEREFORE, in consideration of the exchange of the mutual covenants and promises contained herein, the parties execute this AGREEMENT.

IN WITNESS WHEREOF, the parties have caused their duly authorized representatives to execute this AGREEMENT as of the effective date listed above.

VANTAGE HEALTH PLAN, INC.	EMPLOYER
By: Mike W Breard	By: DeEtte Loyd
Title: Executive Vice President	Title: Director
Date: 11/7/18	Date: 11/7/18

1.0 DEFINITIONS

Accident means bodily injury caused by a sudden and unforeseen event, definite as to time and place.

Accidental Bodily Injury means injury by an accident of external, sudden and unforeseen means.

Adverse Determination means any of the following:

(a) A determination by Vantage that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet Vantage's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Vantage of a Member's eligibility to participate in the health insurance issuer's health benefit plan.

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.

(d) A Rescission of coverage determination.

Affiliated Employer means those employers subsidiary to or affiliated with the contract holder. The Affiliated Employers, if any, are shown in the Group Enrollment Agreement.

Affinity Health Network (AHN) means In-Network Providers with lower Cost Share than the Plan's Standard Network Providers for certain specified Eligible Charges and Prescription Drugs. All AHN Cost Share are shown on the Cost Share Schedule and certain AHN Cost Share are shown on the Member ID Card.

Appeal means the type of complaint a Member files with Vantage to request that Vantage reconsider and change a decision related to Covered Services, (including a denial of, reduction in, or termination of a Covered Service or a failure to make a payment in whole or in part for a Covered Service) or a Rescission of coverage under this Plan.

Authorized Representative means any of the following:

(a) A person to whom a Member has given express written consent to represent the Member. It may also include the Member's treating Health Care Provider if the Member appoints the Health Care Provider as his Authorized Representative and the Health Care Provider waives in writing any right to payment from the Member other than any applicable Cost Share amount. In the event that the service is determined not to be Medically Necessary, and the Member or his Authorized Representatives, except for the Member's treating Health Care Provider, thereafter requests the services, nothing shall prohibit the Health Care Provider from charging usual and customary charges for all non-Medically Necessary services provided.

(b) A person authorized by law to provide substituted consent for a Member.

(c) An immediate family member of the Member or the Member's treating Health Care Provider when the Member is unable to provide consent.

(d) In the case of an urgent care request, a Health Care Provider with knowledge of the Member's medical condition.

Benefit Level means the level at which a Member's Cost Share is paid. Each level (In-Network, Affinity Health Network, and Out-of-Network) has a different Cost Share for the Member as indicated in Section IV of this Certificate of Coverage and/or in the Cost Share Schedule.

Benefit Period means the plan year or contract period for which benefits are covered for the Group Health Plan.

Centers for Medicare and Medicaid Services (CMS) means the federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally-facilitated Marketplace or Exchange.

Chronic Condition or Chronic refers to a medical Illness, disease or physical ailment of long duration (three (3) month duration or longer according to U.S. National Center for Health Statistics) or frequent recurrence, associated with slow progress and long continuance.

Co-insurance means the percentage of the Vantage Allowable the Member is required to pay based on the type of Covered Service and may be due at the time of service. Co-insurance percentages are listed in the Cost Share Schedule and/or in Section IV: *Schedule of Covered Services & Benefits* of the Certificate of Coverage. Co-insurance applies after and does not apply toward the Deductible(s).

Co-payment means the amount the Member is required to pay based on the type of Covered Service and is due at the time of service. Co-payment amounts are listed in the Cost Share Schedule, apply after the Deductible(s), and do not apply toward the Deductible(s).

COBRA refers to the federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 with amendments.

Cosmetic Purposes means services rendered to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structures of any feature of the human body for primarily personal or emotional reasons.

Cost Share means the Deductible(s), Co-payment and Co-insurance amounts or percentages that are the Member's financial responsibility and are based on the type of Covered Service and the Provider network. Member Cost Share amounts apply in the following order: 1) Deductible(s), 2) Co-payment, 3) Co-insurance.

Cost Share Schedule means the document that details the Deductible(s), Co-payment, Co-insurance, and Out-of-Pocket Maximum amounts or percentages that are the Member's financial responsibility and are based on the type of Covered Service and the Provider network.

Covered Service(s) means any Medically Necessary services and supplies, including Prescription Drugs, received upon the recommendation and approval of a Physician and required for the treatment of a Member, subject to the health care benefit offered by Employers to Employees as part of a Group Health Plan under an agreement with Vantage and subject to the exclusions and limitations listed elsewhere in this Certificate of Coverage. Covered Services include services and supplies in accordance with PPACA and state laws, as applicable.

Creditable Coverage means coverage of the Member under any Group Health Plan.

Custodial Care means care that primarily meets personal, comfort or hygiene needs and can be provided by a person without professional skills or training.

Deductible means the amounts shown on the Cost Share Schedule that the Member or family must pay each Benefit Period before certain benefits are payable under the Plan. Deductibles apply to Covered Services to be paid by each Member or family during the Benefit Period. A single family member has met his/her Deductible by reaching the individual Deductible amount. Other family members' payments for Covered Services combine to meet the remainder of the family Deductible amount. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward the Deductible. This Plan's Out-of-Network Deductible does not apply to the Out-of-Pocket Maximum.

Dependent(s) means the spouse or child(ren) or grandchild(ren) designated by an Employee who, by the terms of a Group Health Plan, are eligible or may become eligible to receive Health Insurance Coverage under the Plan.

Developmental Condition or Developmental Disorder refers to an impairment in normal development of language, cognitive and/or motor skills, generally recognized before age eighteen (18) which is expected to continue indefinitely and involves a failure or delay in progressing through the normal developmental stages of childhood.

Drug(s) or Medication(s) refers to all Prescription Drugs and Non-prescription Drugs, including narcotics.

Durable Medical Equipment (DME) is an item that serves a medical purpose only and is Medically Necessary for the treatment of Illness or injury, can withstand long-term repeated use, and is appropriate for home use.

Electronic Medical Records (EMR) is a digital information system which keeps track of medical information and provides a Physician interface that allows the Physician and other Health Care Provider(s) to enter and retrieve patient-specific medical information to support patient medical care.

Eligible Charges means the charges for Covered Services, excluding Prescription Drugs.

Emergency Medical Condition or Emergency is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: (1) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (2) Serious impairment to bodily function; or (3) Serious dysfunction of any bodily organ or part.

Emergency Medical Services are those medical services necessary to screen, evaluate, and Stabilize an Emergency Medical Condition.

Employee means any full-time Employee or former Employee as defined by the Employer and in accordance with state and federal law, or any member or former member of an Employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers Employees of such Employer or members of such organization, or whose Dependents may be eligible to receive any such benefit.

Employer means any person acting directly as an Employer, or indirectly in the interest of an Employer, in relation to an employee benefit plan; and includes a group or association of Employees acting for an Employer in such capacity.

Enrollment Date is defined as the date of enrollment of a Qualified Individual in the Group Health Plan or if earlier, the first day of the Waiting Period for such enrollment.

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

Essential Health Benefits (EHB) means a set of health care service categories that must be covered by certain plans. The Affordable Care Act ensures health plans offer a comprehensive package of items and services, and must include items and services within at least the following ten (10) categories: ambulatory patient services; Emergency Medical Services; hospitalization; maternity and Newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expedited Appeal means an Appeal related to a claim for urgent medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could 1) seriously jeopardize the life or health of the Member; 2) jeopardize the ability of the Member to regain maximum function; or 3) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Final Adverse Determination means an Adverse Determination, including medical judgment, involving a Covered Service that has been upheld by Vantage, or its designee utilization review organization, at the completion of Vantage's internal claims and Appeals process procedures provided pursuant to La. R.S. 22:2401.

Generic Drug means a prescribed therapeutic equivalent (approved by the FDA) of a brand name Prescription Drug that is usually available at a lower cost.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes of chromosomes.

Genetic Testing or Assessment means the examination of Genetic Information contained inside a person's cells to determine if that person has or will develop a certain disease or could pass a certain disease to his or her offspring.

Grievance means the type of complaint a Member files with Vantage for complaints related to Vantage or a Participating Provider about the quality of care received.

Group Health Plan means an employee welfare benefit plan (as defined in 29 U.S.C. Chapter 18 (ERISA) and 42 CFR 3.20) to the extent that the plan provides medical care, including items and services paid for as medical care to Employees or their Dependents, as defined under the terms of the Plan, directly or through insurance, reimbursement or otherwise.

Habilitative Services and Devices means ongoing, Medically Necessary outpatient therapies provided to Members with Developmental Conditions and similar conditions who need habilitation therapies to achieve functions and skills. Habilitative services and devices help a person keep, learn, or improve skills and functioning for daily living.

Health Care Provider(s) may include a Hospital, medical doctor (MD), dentist (DDS or DMD), osteopath (DO), pharmacist (RPh) or pharmacy, registered nurse (RN), nurse practitioner (CNP), physician assistant (PA), registered nurse first assistant (RNFA), occupational therapist, physical therapist, speech therapist, chiropractor, podiatrist (DPM), optometrist (OD), or anesthetist, including certified registered nurse anesthetist (CRNA), licensed by the proper regulatory agency of the state. Health Care Providers may also include a network(s) of any of the Providers listed above.

Health Insurance Coverage means benefits consisting of medical or surgical services, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and federal regulations promulgated pursuant thereto.

Hospital means an institution engaged in providing care and treatment for sick and injured people as bed-patients, which provides care by registered, graduate nurses, on duty or on call doctors available at all times, and has on its immediate premises (except in the case of a Hospital specializing in the care and treatment of Mental or Nervous Disorders) an operating room and related equipment for performing surgery.

> Hospital does not include any establishment (even though it may be called a Hospital) or any part of any establishment which is primarily a place for any of the following: rest, convalescence, Custodial Care, rehabilitation, training, schooling or Occupational Therapy.

Illness means a disorder or disease of the body, or mental or nervous disorder.

In-Network means services obtained from In-Network Providers.

In-Network Cost Share means the Deductible(s), Co-payments and Co-insurance referred to in the "In-Network Cost Share" column in Section IV of this Certificate of Coverage. Certain Covered Services are available from Affinity Health Network Providers at a lower Cost Share.

In-Network Provider(s) or Participating Provider(s) or Participating means those Health Care Providers who have current and valid agreements with Vantage to provide Covered Services to Members of Group Health Plans.

Independent Review Organization (IRO) means an entity that conducts independent external reviews of Adverse Determinations and Final Adverse Determinations.

Late Enrollee is defined as an Employee or Dependent who enrolls under the Plan other than during: 1) the first period in which the individual is eligible to enroll under the Plan, or 2) a Special Enrollment Period.

Life-Threatening Illness means a disease or condition for which the likelihood of death is probable.

Medical Home Primary Care Provider (MH-PCP) means a Participating family practice, general practice, general pediatrician or general internal medicine Physician, selected by a Vantage Member, who provides the Member with entry into the health care system. The Medical Home Primary Care Provider: (1) evaluates the Member's total health needs; (2) provides personal medical care in one or

more medical fields; (3) when Medically Necessary, preserves continuity of care and coordinates care with other Providers of health care services; and (4) coordinates Member care with the Vantage Medical Management department.

Medical Necessity or Medically Necessary means services or supplies, which under the provisions of the contract, are determined to be (1) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; (2) provided for the diagnosis or direct care and treatment of the medical condition; (3) within standards of accepted medical practice within the organized medical community; (4) not primarily for the convenience of the Member, the Member's Physician or other Provider; and (5) the most appropriate supply or level of service that can be safely provided.

> For Hospital stays, this means that acute care as an inpatient is necessary due to the kinds of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less acute care medical setting.

Medicare Opt-Out Physician means any Physician who has opted-out of the Medicare program. When a Physician "opts-out" of Medicare, no services provided by that individual will be covered or reimbursed by Medicare or Vantage, nor will any reimbursement be issued to a Member for items or services provided by that Physician. This Medicare Opt-Out list is available online at *https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z/data*.

Member(s) means an active or retired Employee, his/her eligible Dependent(s), or any other individual eligible for coverage under a Group Health Plan for whom the necessary application forms have been completed and for whom the required premiums have been paid.

Mental or Nervous Disorder(s) means a mental, emotional or behavioral disorder, including, but not limited to neurosis, psychoneurosis, psychosis, personality disorder, and alcohol or Drug addiction.

Minimum Essential Coverage means the type of coverage an individual needs to have to meet the health coverage requirements under PPACA.

Newborn means infants from the time of birth until age one (1) month or until such time as the infant is well enough to be discharged from a Hospital or a neonatal special care unit to the infant's home, whichever period is longer.

Non-Essential Health Benefits (Non-EHB) means Covered Services other than Essential Health Benefits.

Non-prescription Drug(s) means any medicine that does not require a prescription from a Health Care Provider.

Occupational Therapy means a healthcare service to evaluate and treat individuals in order for the individual to participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping people recovering from injury to regain skills and providing support for older adults experiencing physical and cognitive changes.

Out-of-Network means services obtained from Out-of-Network Providers.

Out-of-Network Provider(s) or Non-Participating Provider(s) means those Health Care Providers who do not have a current and valid contract with Vantage at the time services are rendered. Out-of-Network Providers may balance-bill a Member.

Out-of-Pocket Maximum(s) means the specified dollar amounts listed in the Cost Share Schedule for which a Member or family is responsible for Covered Services. Out-of-Pocket Maximums do not include charges for services provided by Out-of-Network Providers. There is no Out-of-Network Out-of-Pocket Maximum. Other exclusions and limitations are described in Section IV of this Certificate of Coverage.

Participating Provider(s) or Participating – See *In-Network Provider* definition.

Patient Protection and Affordable Care Act (PPACA) refers to the federal law enacted on March 23, 2010, along with the Health Care and Education Reconciliation Act of 2010, and all rules and regulations issued thereunder. This law is also sometimes referred to as the Healthcare Reform Law.

Physical Therapy means a healthcare service including evaluation and treatment of any physical or medical condition to restore normal function of the neuromuscular, musculoskeletal, cardiovascular and/or integumentary systems or prevent disability with the use of physical or mechanical means, including therapeutic exercise, mobilization, passive manipulation, therapeutic modalities and activities.

Physician means a medical doctor (MD) or osteopath (DO).

Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with such person ends upon the termination of such legal obligation.

Plan means the Group Health and Prescription Drug Plan as offered in this Certificate of Coverage.

Plan Administrator refers to the party responsible for administering the Group Health Plan for the exclusive benefit of the Members, including an Employer's third party administrator (TPA).

Plan Drug Formulary means a comprehensive listing of Drugs covered by this Plan.

Pre-Authorization means written authorization from Vantage before receiving certain health services.

Prescription Drug(s) means any medicine that requires a prescription from a Health Care Provider who is authorized by federal or state law to prescribe or refill the medicine.

Prescription Drug Deductible means the amount shown on the Cost Share Schedule that the Member must pay each Benefit Period at In-Network pharmacies before certain Prescription Drug benefits are payable under the Plan.

Prosthetic Device or Prosthesis means an artificial limb designed to maximize function, stability, and safety of the patient. Prosthetic Device or Prosthesis also means an artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, nose, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services means the science and Medically Necessary practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting or servicing of a Prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmeses, or both.

Qualified Health Plan (QHP) means an insurance plan that is certified by the Centers for Medicaid and Medicare Services, provides Essential Health Benefits, follows established limits on cost-sharing (such as Deductible(s) and Out-of-Pocket Maximum amounts), and meets other requirements.

Qualified Individual means individuals eligible to purchase and receive Health Insurance Coverage through a Qualified Health Plan.

Reconstructive Services means reparative or therapeutic surgery or services done to restore the patient's function and appearance to pre-injury or pre-Illness state.

Recurrent Condition means defective state of health returning or happening time after time.

Rescission means cancellation or discontinuance of coverage under Vantage that has a retroactive effect. The term shall not include a cancellation or discontinuance of coverage under a health benefit plan if either:

(a) The cancellation or discontinuance of coverage has only a prospective effect.
(b) The cancellation or discontinuance of coverage is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Skilled Nursing Facility means an institution or distinct part of an institution that:

1. Is operated in accordance with the applicable laws of the jurisdiction in which it is located to provide skilled nursing care for sick and injured people; and
2. Provides 24-hour-a-day nursing services under the supervision of a licensed Physician or registered nurse, who is devoted full-time to such supervision; and
3. Maintains clinical records of each patient; and
4. Has appropriate methods and procedures to administer Drugs to patients; and
5. Is not an institution, or part of an institution, that is:
    a. A Hospital; or
    b. Primarily for the care of mental Illness, Drug addiction, alcoholism, or tuberculosis; or
    c. Primarily engaged in providing domiciliary care, Custodial Care, educational care, or care for the aged.

Small Group means any person, firm, corporation, partnership, trust, or association actively engaged in business which has employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

Special Enrollment Period is the sixty (60) days after a qualifying event (which are listed in Section VI of this Certificate of Coverage) in which a Qualified Individual may enroll in this Plan. A Special Enrollment Period of sixty (60) days is allowed when a Qualified Individual or Dependent of a Qualified Individual has a change in eligibility or premium assistance under a Medicaid or CHIP program.

Specialty Care Provider is a medical or surgical Physician other than those defined as Medical Home Primary Care Providers.

Specialty Drugs include high cost Drugs and pharmaceuticals produced through DNA technology or biological processes that target Chronic or complex disease states and require unique handling, distribution, or administration as well as a customized medical management program for successful use.

Speech Therapy means a healthcare service to evaluate, treat, and diagnose speech, language, cognitive-communication and swallowing disorders in individuals of all ages from infants to the elderly.

Standard Network – In-Network Providers other than the Affinity Health Network Providers.

Temporarily Medically Disabled Mother means a woman who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

Tier II Provider or Tier II – A nationwide Provider network available to Members living outside of the Vantage Service Area (state of Louisiana). Tier II Providers outside the Vantage Service Area cannot balance-bill out-of-state Members. Members living in the Vantage Service Area do not have access to the Tier II Provider network.

Urgent Care Center means a Physician's office, clinic or other facility primarily engaged in treating patients whose conditions require immediate medical attention. The term Urgent Care Center does not include Hospital emergency department, other outpatient emergency department or other outpatient Hospital facility.

Utilization Review/Quality Management (UR/QM) means a function performed by Vantage or its designee to review and approve or deny authorization or payment for Covered Services as to the Medical Necessity and quality of the care and compliance with agreed-upon policies, procedures and protocols established by Vantage.

Vantage Allowable means the amount Vantage would pay to a Participating Provider for the Covered Service as specified in the Provider contract or the amount set forth in the Vantage Allowable fee schedule, as determined by Vantage.

Vantage Service Area means the geographic area served by Vantage as approved by the Louisiana Department of Insurance and defined by the Employer for purposes of eligibility and enrollment in this Plan.

Waiting Period is defined as the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Plan.

2.0 RELATIONSHIP BETWEEN THE PARTIES

2.1 VANTAGE and EMPLOYER shall function as independent entities for the purposes of their respective responsibilities under this AGREEMENT. This AGREEMENT shall be construed or deemed to create a relationship of independent parties contracting with each other solely for the purpose of carrying out the provisions of this AGREEMENT.

2.2 Nothing in this AGREEMENT shall be construed as creating a partnership, joint venture or employment relationship between VANTAGE, EMPLOYER and/or Participating Providers.

2.3 Participating Providers shall be solely responsible for all medical care and services to Members.

3.0 MEMBERSHIP

3.1 Employees, Dependents and others named as individuals eligible for health care benefits shall be as provided for in the Group Enrollment Agreement attached herewith and incorporated by reference (Addendum C) and the Member Certificate of Coverage attached hereto and incorporated herein by reference (Addendum A).

3.2 VANTAGE agrees to accept all applications for Employee enrollment without regard to race, color, creed, marital status, sex, age, national origin, mental impairment, or any federally protected characteristic not listed herein.

3.3 VANTAGE will not expel or refuse to renew the coverage of any individual Member of a subscriber group on the basis of any federally protected characteristic, health status, health care needs, or prospective costs of health care services of the Member.

4.0 ENROLLMENT

4.1 EMPLOYER agrees to offer VANTAGE benefits to all currently eligible Employees and their Dependents and to all newly hired Employees and their Dependents when eligibility requirements are satisfied. Individuals (Employee, spouse, child(ren), grandchild(ren)) will not be denied coverage because of any health related factor. All Members of the group will be able to participate in the Plan when the Member first becomes eligible to enroll. Unless otherwise approved by VANTAGE or under conditions of Special Enrollment Periods as defined in Section 1.0 (Definitions) of this AGREEMENT, currently eligible Employees and their Dependents may not be added to this Plan outside the Open Enrollment Period, which is defined in the Group Enrollment Agreement.

4.2 VANTAGE reserves the right to terminate this AGREEMENT if a minimum percentage (minimum participation) of eligible Employees do not select this Plan.

4.3 VANTAGE may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this Plan. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the effective date or terminated within three (3) years of the Member's effective date, for fraud or intentional misrepresentation of material fact. VANTAGE will give the Member thirty (30)

days advance written notice prior to rescinding or terminating coverage under this section.

5.0 BENEFITS PROVIDED

5.1 Payment will be provided for the Covered Services listed in Addendum A, for services actually received or expenses incurred by a Member while covered under this Plan. Covered Services are the Medically Necessary services and supplies received upon the recommendation and approval of a Participating Provider and required for the treatment of a Member, subject to the benefit exclusions and limitations listed in Addendum A. Eligible charges incurred for such services are subject to the co-payments and maximums shown in the Schedule of Covered Services and Benefits (Addendum A).

5.2 When Covered Services are rendered by a Participating Provider in the VANTAGE Service Area, coverage will be provided as described in the Schedule of Covered Services and Benefits (Addendum A). Emergency services rendered outside the VANTAGE Service Area will also be covered by VANTAGE, subject to the benefit specifications outlined herein. VANTAGE will have no liability or obligation for any benefits or services sought or received by a Member from a Non-Participating Provider or any provider outside the VANTAGE Service Area unless Pre-Authorization has been granted by VANTAGE, except for Emergency Medical Services.

5.3 THE MEMBER'S SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN VANTAGE AND THE PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW THE PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES. HOWEVER, PARTICIPATING PROVIDERS ARE BOUND BY AN AGREED-UPON FEE SCHEDULE AND MAY NOT BILL MEMBERS FOR AMOUNTS IN EXCESS OF THE FEE SCHEDULE FOR COVERED SERVICES.

6.0 EMPLOYEE CONTRIBUTION BASIS

The requirements, as established by EMPLOYER and approved by VANTAGE, for Employee contributions are as shown in the Group Enrollment Agreement. EMPLOYER agrees to contribute a minimum of sixty percent (60%) toward the single premium.

7.0 EMPLOYER RESPONSIBILITIES

EMPLOYER agrees to:

7.1 Furnish to VANTAGE all information necessary for the calculation of subscription fees and all other necessary information for the efficient administration of the Health Insurance Coverage provided under this AGREEMENT. VANTAGE shall have the right to examine any records of EMPLOYER which have a bearing on the benefits under this AGREEMENT, at any reasonable time during the term of this AGREEMENT and subsequently until all rights and obligations under this AGREEMENT have ended. Failure on the part of EMPLOYER to furnish any necessary information may result in coverage not taking effect (unless otherwise

provided), invalidating coverage otherwise validly in effect, or continuing coverage otherwise validly terminated.

7.2 Reconcile on a monthly basis VANTAGE's itemized premium billing statement with EMPLOYER's payroll records to confirm the coverage of each Employee and/or Dependent who is eligible to receive and requested coverage under this AGREEMENT. Any discrepancy should be reported immediately in writing by EMPLOYER to VANTAGE. EMPLOYER's failure to reconcile the said records may result in coverage being delayed or denied for an otherwise eligible Employee and/or Dependent. EMPLOYER shall be responsible for all costs, including unpaid premiums, attributable to its failure to reconcile the said records accurately.

7.3 Pay VANTAGE for any premiums or other costs due as a result of EMPLOYER requesting a retroactive addition, termination, or change ("retro-change") of an Employee and/or Dependent. No such retro-change, however, shall take effect beyond sixty (60) days prior to VANTAGE's receipt of the request from EMPLOYER.

7.4 Reimburse VANTAGE any and all unrecoverable monies for services, treatments and/or prescription benefits related to Members retroactively terminated. These may include, but are not limited to, authorized services to non-participating providers and medications provided by VANTAGE's pharmacy benefit management company.

7.5 EMPLOYER shall pay any unpaid balance on previous VANTAGE coverage before being allowed to re-enroll with VANTAGE during an annual enrollment period. EMPLOYER shall pay the balance due (which could include any outstanding premium balance) as reflected on their first premium billing statement from VANTAGE before the new coverage will take effect. EMPLOYER should address any questions regarding its premium bills to VANTAGE's Marketing department.

7.6 Notify VANTAGE within thirty (30) days of any termination of an eligible Employee or Member.

8.0 VANTAGE RESPONSIBILITIES

VANTAGE agrees to:

8.1 Maintain a network of health care providers under contract with VANTAGE who will render Covered Services to Members enrolled and covered under this AGREEMENT.

8.2 Furnish to each covered Employee, an individual certificate summarizing the essential provisions of Coverage within twenty (20) working days from approval of the enrollment form by VANTAGE or by the effective date of Coverage. Nothing contained in the certificate will be construed to change, modify or invalidate any of the terms and conditions of this AGREEMENT.

8.3 Cooperate with EMPLOYER in resolving any disputes that may arise between EMPLOYER and their eligible Employees or Participating Providers with VANTAGE.

8.4 Vantage shall pay claims timely and in accordance with the state law. Electronic clean claims received from all Health Care Providers shall be paid within twenty-five (25) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers within forty-five (45) days from the date of service shall be paid within forty-five (45) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers after forty-five (45) days from the date of service shall be paid within sixty (60) days of date of receipt by Vantage. All non-electronic clean claims received from Non-Participating Providers shall be paid within thirty (30) days from date of receipt by Vantage.

9.0 SUBSCRIPTION FEES

9.1 VANTAGE monthly subscription fees (subscription rate or monthly premium), as stipulated in the Group Enrollment Agreement, are payable in advance of the contract's effective date and by the first day of each subsequent month. In no case should the payment be received later than thirty (30) days after the first of each month.

9.2 The amount due and payable each month will be calculated by multiplying the number of eligible up-to-date Members in each rate category shown in the table of subscription fees by the rate in effect on that day for that category and adding the results. Any additions, terminations, and changes received by VANTAGE after the tenth of each month will be reflected on the next month's premium.

9.3 This AGREEMENT has a thirty (30) day grace period. This provision means that if any required subscription fees are not paid on or before the date it is due, it may be paid during the grace period. During the grace period, this AGREEMENT will remain in force, except that for groups where subscription fees have not been received when due, claims for Members covered by this AGREEMENT may, at the option of VANTAGE, be held and suspended from processing until the subscription fees have been paid by EMPLOYER. EMPLOYER shall be liable to VANTAGE for the pro rata portion of the subscription fee, which accrues for the time this AGREEMENT remains in effect. This AGREEMENT will be considered cancelled unless the subscription fees past due and current are fully paid by the end of the grace period.

9.4 If any subscription fees are not paid within the specified grace period, a subsequent acceptance of the premium by VANTAGE shall reinstate the policy as though it had never terminated, unless VANTAGE within thirty (30) days of receipt of such payment, either refunds the payment so made or issues to EMPLOYER a new AGREEMENT which may differ in benefits, coverage or otherwise.

9.5 VANTAGE may change any subscription rate for any coverage on the first anniversary date of this AGREEMENT and on any subsequent due date by written notice to EMPLOYER at least forty-five (45) days before such change becomes effective. VANTAGE shall have the right to change rates immediately, if in its opinion any act by the Louisiana legislature or by Congress or any change in the coverage provided by this AGREEMENT changes its liability under this AGREEMENT. Any such change in rates will take effect on the effective date of any such state or federal legislation or change in coverage.

9.6 This AGREEMENT constitutes notice of VANTAGE's cancellation policy and the necessary action to be taken for reinstatement to be achieved.

10.0 LIMITATION OF RESPONSIBILITY

Except as EMPLOYER may be advised by VANTAGE from time to time, VANTAGE is not obligated in any way to provide health care services directly, but shall make available a network of Participating Providers who are under contract with VANTAGE to provide Covered Services to Members under this AGREEMENT.

11.0 USE OF COMPANY NAMES

EMPLOYER specifically gives VANTAGE the right to use its company name in marketing VANTAGE services by listing EMPLOYER in brochures and other descriptive materials as one of the entities who has signed a contract to utilize VANTAGE services.

12.0 PROTECTION OF MEMBER HEALTH INFORMATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) ("HIPAA"), VANTAGE prohibits the sharing of Member Protected Health Information ("PHI") with EMPLOYER, unless EMPLOYER agrees to the following:

12.1 Not use or disclose PHI, other than as permitted by VANTAGE, the MEMBER or as required by state or federal law;

12.2 Ensure that agents and subcontractors of EMPLOYER agree to the same restrictions and conditions as EMPLOYER, with regard to PHI;

12.3 Prohibit the use of PHI by EMPLOYER for employment or other benefit-related decisions;

12.4 Notify VANTAGE of any use or disclosure of PHI that is inconsistent with use and disclosure established in the Certificate of Coverage or other plan documents;

12.5 Allow Member access to PHI, including access to amend his/her PHI;

12.6 Make necessary information available to VANTAGE in order to provide Members with an accounting of disclosure(s);

12.7 Upon request, make available procedures for return, destruction and restriction of further use of PHI by EMPLOYER; and

12.8 Identify any employee of EMPLOYER who may have access to Member PHI.

In the event that either VANTAGE or EMPLOYER is made aware of a breach of privacy or inappropriate use of PHI, the other party and Member(s) involved will be immediately notified. VANTAGE and EMPLOYER will work together to resolve any such problem. Actions may include, but are not limited to additional training and audits performed by VANTAGE and EMPLOYER.

13.0 DISPUTE RESOLUTION

13.1 EMPLOYER and VANTAGE agree to meet and confer in good faith to resolve any problems or disputes that may arise under this AGREEMENT.

13.2 If EMPLOYER and VANTAGE are unable to resolve any problem or dispute that may arise under this AGREEMENT, each shall have the right to pursue legal recourse against the other.

14.0 EFFECTIVE DATE

14.1 This AGREEMENT is effective on the date specified in the Group Enrollment Agreement and noted above and will be continued in force by the timely payment of the required subscription fees when due subject to termination of this AGREEMENT as provided herein.

14.2 All periods of Coverage under this AGREEMENT will commence at 12:01 a.m. Central Time.

14.3 VANTAGE will renew or continue in force group health coverage at the option of the plan sponsor of the plan pursuant to LSA R.S. 22:1068 and in accordance with Section 14.1.

15.0 TERMINATION

This AGREEMENT may be terminated for the following causes and in the following manner:

15.1 This AGREEMENT may be terminated by either party at the anniversary date of this AGREEMENT by giving written notice to the other party at least sixty (60) days prior to the anniversary date. Unless otherwise terminated, this AGREEMENT will automatically renew from year to year and will be subject to new subscription rates on an annual basis.

15.2 If EMPLOYER fails to comply with its material obligations under the terms and conditions contained herein or within any addendum or appendix hereto, VANTAGE may terminate this AGREEMENT by giving EMPLOYER at least sixty (60) days prior written notice of termination. If VANTAGE fails to comply with its material obligations under the terms and conditions contained herein or within any addendum or appendix hereto, EMPLOYER may terminate this AGREEMENT by giving VANTAGE at least sixty (60) days prior written notice of termination. Any notice of termination shall state the reason or reasons for the cancellation or termination.

15.3 In the event the Group Health Plan is cancelled, EMPLOYER shall provide notice of cancellation to each subscriber under this Plan. If notice is required due to VANTAGE's failure to comply with its material obligations, pursuant to Section 14.2, the cost of such notice will be borne by VANTAGE.

15.4 Upon termination of this AGREEMENT, EMPLOYER and VANTAGE agree to attempt, in good faith, to resolve all outstanding financial issues between them, as more particularly described in Section 13.0 above.

16.0 GENERAL PROVISIONS

16.1 **Entire Agreement**
This AGREEMENT, the Group Enrollment Agreement of the contract holder (a copy of which is attached), any and all addenda and appendices attached hereto and incorporated herein by reference, and the applications, if any, of the Employees, constitute the entire AGREEMENT between the parties. No waiver, modification or change in any provision of this AGREEMENT shall be effective unless and until approved in writing by a duly authorized officer of VANTAGE and EMPLOYER evidenced by an endorsement attached to this AGREEMENT. Any statements made by the contract holder, or by an Employee will, in the absence of fraud, be deemed representations and not warranties. No such statement will void the coverage, reduce benefits under the AGREEMENT or be used in defense to any claim under the AGREEMENT after it has been in force for two (2) years from the effective date, unless such statement is contained in a written instrument signed by the contract holder, or the Employee, a copy of which is or has been furnished to the contract holder or to the Employee or his Beneficiary, if any.

16.2 **Incontestability**
The validity of a provision of this AGREEMENT will not be contested, except for non-payment of subscription fees, after such provision has been in force for two (2) years from its effective date.

16.3 **Workers' Compensation**
This contract is not in lieu of and does not affect any requirement for coverage by any Workers' Compensation, Occupational Disease, Employer's Liability Act or similar law.

16.4 **Benefit Funding**
The funding for the benefits of this Plan is derived from the funds of the Employer and contributions made by covered Employees. The Plan is insured.

16.5 **Successors and Assigns**
This AGREEMENT shall be binding upon and inure to the benefit of the parties, their successors and assigns. This AGREEMENT and the rights and obligations conferred thereunder shall not be assignable by either party unless agreed to by the mutual consent of both parties; however, no such consent shall be required in the event of an assignment to a parent, subsidiary, affiliate, or successor that is not a competitor of the other party of the surviving entity or merger.

16.6 **Waiver of Breach**
Waiver of a breach of any provision of this AGREEMENT shall not be deemed a waiver of any other breach of the same or different provision.

16.7 **Notices**
All notices or demands under this AGREEMENT shall be in writing and shall be deemed to have been duly given if delivered by hand with a receipt given by an authorized representative of one of the respective organizations or when mailed by registered mail, return receipt requested, postage prepaid and addressed as follows:

If to VANTAGE:
Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201

If to EMPLOYER:
University Academy of Central LA
141 Middleton Dr
Alexandria, LA 71302

16.8 **Severability**
In the event any provision of this AGREEMENT is rendered invalid or unenforceable by any Louisiana or federal statute, or regulation thereunder or declared invalid or unenforceable by any court of competent jurisdiction, the remainder of the provisions of this AGREEMENT shall remain in full force and effect. In the event a provision of this AGREEMENT is rendered invalid or unenforceable as provided above and its removal has the effect of materially altering the obligations of either party in such manner as in the judgment of the party affected, (a) will cause serious financial hardship to such party, or (b) will cause such party to act in violation of its corporate articles or bylaws, the party so affected shall have the right to terminate this AGREEMENT upon sixty (60) days written notice to the other party.

16.9 **Amendment**
This AGREEMENT may be supplemented, amended or revised only in a writing executed by VANTAGE and EMPLOYER. No agent has authority to change this AGREEMENT or waive any representation. The validity of any change to this AGREEMENT will not be affected by the failure to notify or obtain the consent of any Employee or any other person having a beneficial interest under the AGREEMENT.

16.10 **Attorney's Fees**
In the event that either VANTAGE or EMPLOYER institutes any legal action against the other to enforce the provisions of this AGREEMENT, the prevailing party shall be entitled to recover all of its costs and attorney's fees incurred in pursuing such action.

16.11 **Construction of Terms**
As used in this AGREEMENT, the singular number includes the plural, the plural number includes the singular, and a pronoun or other word of any gender includes all genders, unless the context clearly provides otherwise. The headings of sections or paragraphs, bolding, underscoring and other methods of emphasis contained in this AGREEMENT are for reference or readability purposes only and shall not affect in any way the meaning or interpretation of this AGREEMENT.

16.12 **Governing Law**
This AGREEMENT shall be governed by and construed in accordance with the laws of the State of Louisiana.

IN WITNESS WHEREOF, the parties have caused their duly authorized representatives to execute this AGREEMENT:

Vantage Health Plan, Inc.	EMPLOYER
By: Mike W Brand	By: DeEtta Lloyd
Title: Executive Vice President	Title: Director
Date: 11/7/18	Date: 11/7/18

ADDENDUM C

MASTER GROUP CONTRACT
Vantage Health Plan, Inc.

GROUP ENROLLMENT AGREEMENT

I. **Contract Holder**

Company Name: University Academy of Central LA

Physical Address: 141 Middleton Dr

Alexandria, LA 71302

Contact Name and Phone Number: Deette Loyd (318)427-0123

II. **Effective Date:** September 1, 2018

Anniversary Date: September 1, 2019

Minimum Participation Required: Seventy-five percent of the total number of eligible Employees and not less than fifty-percent of total Employees.

Total number of Employees:

Total number of Insured Employees:

A Quarterly Wage & Tax Statement must be received by Vantage prior to the completion of this Group Enrollment Agreement.

III. **Classes of Employees to be Covered**

__X__ **Active** _____ **Retiree**

__X__ **COBRA:** Direct (2% administration fee applies to rates)

IV. **Subscription Fees/Monthly Premium:**

Employer group representatives will receive a monthly Group Statement for the members billed on the group's account.

V. **Payment of Fees:**

Monthly subscription fees are payable in accordance with the terms of the Master Group Contract, Section 9.0. The Employer Representative is responsible for the collection of Vantage premiums. Payment is to be submitted, with a copy of the Vantage Group Statement, to:

Vantage Health Plan, Inc.
ATTN: Accounting Department
130 DeSiard Street, Suite 300
Monroe, LA 71201

ALL OTHER CORRESPONDENCE SHOULD BE ADDRESSED TO:

Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201

* Additional copies of the Master Group Contract and your group's plan documents are available upon request. Please contact Vantage Health Plan to request these documents.

VI. Services and Benefits

(Refer to Addendum E – Cost Share Schedule)

Medical Benefits:	**Cost Share:**
In-Network Medical Deductible	$750 Individual Member $1,500 Family
PCP Office Visit	$15 Co-payment
Specialist Office Visit	$50 Co-payment
In-Network Medical Co-insurance	30% Co-insurance
Pharmacy Benefits:	
In-Network Rx Deductible	$0 Individual Member $0 Family
Tier 1/Tier 2/Tier 3/Tier 4/Tier 5	$3/$15/$45/$95/33%

VII. Employee Eligibility and Termination

(a) **Minimum number of hours** worked per week (minimum of 20 hours per week for permanent full-time or part-time employees required): 40 hours

(b) **Waiting period of days.** (As specified by each employer, not to exceed 90 days)
Exempt: 1st of the month following date of hire
Non-Exempt: 1st of the month following date of hire

(c) Effective date of termination is the end of the month following termination of employment.

VIII. Open Enrollment Period

Employer agrees to offer Vantage benefits to all currently eligible Employees and to all newly hired Employees when eligibility requirements are satisfied. Unless otherwise approved by Vantage or through a Special Enrollment Period, currently eligible Employees and their family members may not be added to this Plan outside the Open Enrollment Period of August, 1st to August, 31st annually.

IX. Continuation of Coverage

For employer groups of 20 Employees or more, COBRA regulations will apply and the Employer is responsible for Member notification and individual premium billings and collections. Vantage agrees to accept COBRA beneficiaries from other health plans during the Open Enrollment Period and within 31 days of relocation to within the Vantage Service Area.

VANTAGE HEALTH PLAN, INC.	EMPLOYER REPRESENTATIVE
Name (Print): Mike Breard	Name (Print): DeEtte Loyd
Signature: Mike W Breard	Signature: DeEtte Loyd
Title: Executive Vice President	Title: Director
Date: 11/7/18	Date: 11/7/18

* Additional copies of the Master Group Contract and your group's plan documents are available upon request. Please contact Vantage Health Plan to request these documents.

ADDENDUM D

Plan Sponsor Certification to Group Health Plan

Vantage Health Plan, Inc. and its affiliates and subsidiaries (the "Plan Sponsor") hereby certifies that the plan documents for the Employee Group Health Plan include the following provisions which restrict the use and disclosure of individually identifiable health information (Protected Health Information), and that the Plan Sponsor agrees to comply with the restrictions on use and disclosure contained in the plan documents and the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations on privacy and confidentiality. The Plan Sponsor agrees to:

1. Not use or further disclose Protected Health Information other than as permitted by the plan documents or as required by law;
2. Ensure that any agent (including a subcontractor) who receives Protected Health Information from the Employee Group Health Plan agrees in advance to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Employee Group Health Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures permitted herein;
5. Make available to a member his/her Protected Health Information in accordance with 45 C.F.R. Section 164.524;
6. Make available to a member his/her Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. Section 164.526;
7. Make available to a member the information required to provide an accounting of disclosures of his/her Protected Health Information in accordance with 45 C.F.R. Section 164.528;
8. Make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Employee Group Health Plan available to the U.S. Secretary of Health and Human Services for purposes of determining compliance by the Employee Group Health Plan with 45 C.F.R. Section 164.504(f);
9. If feasible, return or destroy all Protected Health Information received from the Employee Group Health Plan that the Plan Sponsor maintains in any form and retain no copies of such information when such information is 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 the purposes that make the return or destruction of the information feasible; and
10. Ensure that the adequate separation between the Employee Group Health Plan and the Plan Sponsor required by 45 C.F.R. Section 164.504(f)(2)(iii) is established and maintained.
11. Identify the Plan Sponsor or Plan Sponsor's staff who have access to PHI and take appropriate action in the event an employee, agent or contractor of Plan Sponsor inappropriately uses or discloses Protected Health Information. Such action could include but not be limited to disciplinary measures, termination of services or redress through court action.

Plan Sponsor University Academy of Central LA

Authorized Signature DeEtte Loyd

Name (Print) DeEtte Loyd

Title Director Date 11/7/18

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