Individual Market Medicare Exchange Health Reimbursement Arrangement

for

The State of Louisiana
an ERISA Exempt Employer

2013

Office of Group Benefits
Division of Administration
State of Louisiana

Article 1
INTRODUCTION

1.1 Establishment of Individual Market Medicare Exchange Health Reimbursement Arrangement Plan

The Office of Group Benefits (OGB), Division of Administration, State of Louisiana hereby establishes the Individual Market Medicare Exchange Health Reimbursement Arrangement Plan (IMEHRA), effective January 1, 2013.

The purpose of this IMEHRA is to permit participating Retirees to obtain reimbursement of Qualifying Medical Care Expenses on a non-taxable basis from their IMEHRA Account.

Capitalized terms used in this Plan Document that are not otherwise defined in this Plan Document shall have the meanings set forth in Article 2.

1. 2 Legal Status

This IMEHRA is intended to: (1) qualify as an "employer-provided medical reimbursement plan" under §105 and §106 of the Internal Revenue Code; (2) qualify as a health reimbursement arrangement as defined under IRS Notice 2002-45; (3) allow the Qualifying Medical Care Expenses reimbursed under this Plan to be eligible for exclusion from Participants' gross income under Code §105(b); and, (4) comply with the Internal Revenue Code and the regulations issued thereunder.

The provisions of this IMEHRA shall be interpreted to accomplish these objectives.

Article 2
DEFINITIONS and CONSTRUCTION

2.1 Definitions

"Account(s)" means the IMEHRA accounts described in Section 5.3.

"Administrator" means the Office of Group Benefits (OGB), Division of Administration, State of Louisiana or other such person or entity that it appoints as its designee.

"Annual Enrollment Period" means the period designated by the Administrator, which precedes the commencement of each Plan Year, during which eligible Retirees can elect to participate in this IMEHRA.

"Appeals Panel" means the panel of at least three (3) individuals appointed by the Administrator.

"Benefits" means any amounts credited to a Participant's Account in this IMEHRA for reimbursement of Qualifying Medical Care Expenses incurred by the Participant, or Participant Dependent during a Plan Year, and/or Spend-Down Period.

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

"Code" means the Internal Revenue Code of 1986, as amended.

"Dependent" means: (1) any individual who is a tax dependent of a Participant as defined in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; (2) any child (as defined in Code §152(f)(1)(B)) of the participant who has not attained age 26; and, (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding a child of divorced or separated parents where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the year). Notwithstanding the foregoing, this IMEHRA will provide Benefits in accordance with the applicable requirements of any NMSN, even if the child does not meet the definition of "Dependent."

"Effective Date" means the date that this IMEHRA is effective, January 1, 2013.

"Employer" means the State of Louisiana through the respective Department or Agency that employed the Participant.

"**Enrollment Form**" means the form provided by the Employer or Administrator for the purpose of allowing a Retiree to enroll in this IMEHRA, in accordance with Section 3.1.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**IMEHRA**" means the Individual Market Medicare Exchange Health Reimbursement Arrangement that is a limited retiree HRA, as set forth herein and as amended.

"**Individual Market Medicare Exchange**" means the health care exchange for Medicare eligible individuals sponsored by the Office of Group Benefits, Division of Administration, State of Louisiana (OGB).

"**National Medical Support Notice (NMSN)**" means the standardized form used by state child support enforcement agencies to obtain group health coverage for children, deemed to be a QMCSO when appropriately completed.

"**Participant**" means a person who is a Retiree and who is participating in this IMEHRA in accordance with the provisions of Article 3.

"**Participant Dependent**" means a person who is the spouse or Dependent of a Participant and who is participating in this IMEHRA in accordance with the provisions of Article 3.

"**Plan Year**" means the period of coverage under the IMEHRA from January 1 through December 31 of each year, except in the case of a Short Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire Short Plan Year.

"**Prescription**" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state of the United States of America in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state. See IRS Notice 2010-59.

"**QMCSO**" means a Qualified Medical Child Support Order, as defined in ERISA §609(a).

"**Qualifying Medical Care Expenses**" means an expense incurred by a Participant, or by a Participant Dependent, for medical care as defined in Code §213(d) and Treasury Regulations §1.213-1(e), including amounts paid for insurance premiums, but only to the extent that the Participant or

Participant Dependent incurring the expense is not reimbursed for the expense through insurance or otherwise. Charges for medicines or drugs, other than insulin, must be prescribed and must be purchased within the United States. Amounts paid for medicines or drugs, other than insulin, purchased outside the United States are **NOT** Qualifying Medical Care Expenses. A Qualifying Medical Care Expense is incurred when the medical care is provided, not when the participant is formally billed, charged for, or pays the expenses.

"Retiree" means a retiree of the State of Louisiana through the respective Department or Agency that employed the Participant(s).

"Run-Out Period" means the two months immediately following the Spend-Down Period when Participants who cease may submit Qualifying Medical Care Expenses incurred during any preceding Plan Year and/or the Spend-Down Period.

"Short Plan Year" means the period of coverage under the IMEHRA designated by the Administrator that is less than one year.

"Spend-Down Period" means the two months immediately following a Participant's loss of eligibility.

2.2 Gender and Number

Except when otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and the definition of any term herein in the singular shall also include the plural.

2.3 Headings

The headings of the various Articles and subsections are inserted for convenience of reference and are not to be regarded as part of this IMEHRA Plan Document or as indicating or controlling the meaning or construction of any provision.

Article 3
PARTICIPATION

3.1 Eligibility to Participate; Effective Dates of Coverage

Participation in the IMEHRA shall begin January 1, following the Annual Enrollment Period in which:

(a) the Retiree; his spouse; and/or Dependent, are covered by OGB Plan coverage and coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B);

(b) the Retiree; his spouse; and/or Dependent, enroll for coverage in an individual Medicare Advantage Plan; Medigap Plan; or Medicare Prescription Drug Plan through the OGB sponsored Individual Market Medicare Exchange; and

(c) the Retiree's enrollment information is sent electronically to the Administrator.

3.2 Cessation of Participation

Participation in the IMEHRA will end:

(a) on the date the Participant or the Participant's Dependent ceases to be eligible to participate for any reason, including but not limited to:

(1) enrollment in other coverage that precludes enrollment in the individual Medicare plan selected through the Individual Market Medicare Exchange sponsored by the OGB;

(2) full-time employment of the Participant or the Participant's Dependent that results in the respective individual Medicare plan coverage to be secondary coverage;

(3) ineligibility for an individual Medicare Plan coverage; or

(4) death;

(b) on the effective date of any IMEHRA amendment that renders the Participant and/or the Participant's Dependent ineligible to participate in the IMEHRA;

(c) on the effective date of termination of the IMEHRA;

(d) with respect to a Participant Dependent, the date he ceases to be a Dependent for any reason, including but not limited to:

(1) death;

(2) divorce;

(3) loss of dependent status pursuant to Code §152; or

(4) cessation of participation of the Participant.

Reimbursement from the IMEHRA Account after termination of the Participant's participation shall be governed by Sections 5.6, 5.7, 5.8, 5.9, or 5.10, as appropriate.

Article 4
BENEFITS and FUNDING

4.1 Benefits

The IMEHRA will reimburse Participants for Qualifying Eligible Medical Expenses, up to the unused amount in each Participant's IMEHRA Account. A Participant shall be entitled to reimbursement under the IMEHRA only for Qualifying Eligible Medical Expenses incurred after he becomes a Participant in the IMEHRA and during a Plan Year and/or Spend-Down Period. In no event shall any benefits under this IMEHRA be provided in the form of cash or any other taxable or non-taxable benefit other than the reimbursement of Qualifying Eligible Medical Expenses.

4.2 Employer and Participant Contributions

(a) *Employer Contributions.* Each Participant's Employer will fund the full amount of his IMEHRA Accounts.

(b) *No Participant Contributions.* Participant contributions are prohibited under the IMEHRA.

(c) *No Funding Under Cafeteria Plan.* Funding Benefits under a cafeteria plan is prohibited under the IMEHRA.

4.3 Funding

All of the amounts payable under the IMEHRA shall be paid from the general assets of the Administrator. Nothing herein will be construed to require the Administrator to maintain any fund or to segregate any amount for any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Administrator from which any payment under this IMEHRA may be made. There is no trust or other fund from which Benefits are paid.

Article 5
REIMBURSEMENT PROCEDURE

5.1 Benefits

The IMEHRA will reimburse Participants for Qualifying Eligible Medical Expenses, up to the unused amount in the Participant's IMEHRA Account.

5.2 Maximum Benefits

The maximum dollar amount that may be credited to an IMEHRA account for Participant only coverage is a $200 monthly accrual, which equals to $2,400 annually. The maximum dollar amount that may be credited to an IMEHRA account for a Participant plus Participant Dependent coverage is a $300 monthly accrual, which equals to $3,600 annually. Unused amounts may be carried over to the next Plan Year, as provided in Section 5.8.

For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Participants through Annual Enrollment documents.

5.3 Establishment of Account

The Administrator will establish and maintain an IMEHRA Account with respect to each Participant, but will not create a separate fund or otherwise segregate assets for this purpose. The IMEHRA Account so established will merely be a recordkeeping account with the purposes of keeping track of contributions and available reimbursement amounts.

(a) *Crediting of Accounts.* A Participant's IMEHRA Account will be credited at the beginning of each calendar month with an amount equal to the applicable annual maximum dollar limit for Plan Year divided by the number of months in that Plan Year (e.g., divided by 12 in a 12-month Plan Year), increased by any carryover of the Participant's unused IMEHRA Account balance from any prior Plan Year.

(b) *Debiting of Accounts.* A Participant's IMEHRA Account will be debited during each Plan Year for each reimbursement of Qualifying Medical Care Expenses made during the Plan Year.

(c) *Available Amount.* The amount available for reimbursement of Qualifying Medical Care Expenses is the amount credited to the Participant's IMEHRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

5.4 Amount of Reimbursement

At all times during a Plan Year, a Participant shall be entitled to Benefits under the IMEHRA for reimbursement of Qualifying Eligible Medical Expenses in an amount that does not exceed the balance of his Account. Each reimbursement hereunder shall be a charge to such Account.

5.5 Reimbursement Procedure

(a) *Claims Substantiation:* All claimed Qualifying Eligible Medical Expenses are to be verified prior to reimbursement. To receive reimbursement for Qualifying Eligible Medical Expenses under the IMEHRA, a Participant shall submit a claim form and the following information:

(1) A written bill from an independent third party stating the date that the Qualifying Eligible Medical Expense was incurred, the amount of such expense, and a receipt showing payment has been made.

(2) A brief description and the purpose of the Qualifying Eligible Medical Expense;

(3) The name of the person for whom the Qualifying Eligible Medical Expense was incurred; and,

(4) A statement that the Participant has not been and will not be reimbursed for the Qualifying Eligible Medical Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Qualifying Eligible Medical Expense under Code §213.

(b) *Timing:* The Administrator will reimburse the Participant for Qualifying Eligible Medical Expenses up to the balance in his Account at such intervals as OGB may deem appropriate (but not less frequently than monthly). A claim shall be adjudicated within thirty (30) days of receipt. If an extension is necessary due to matters beyond the control of the plan, the claimant shall be notified within the initial thirty (30) day period that an additional fifteen (15) days is needed to review the claim. When an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information the claimant will need to provide. The claimant will have no less than forty-five (45) days from the date he receives the notice to provide the requested information. A written notice shall be sent for each denied claim with the following information:

(1) The specific reason or reasons for the denial;

(2) The specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to correct the claim and an explanation of why such material or information is necessary;

(4) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to the claimant free of charge upon request; and

(5) A description of the IMEHRA's appeal procedures and the time limits applicable to such procedures, including contact information for member assistance provided by the Administrator and contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT), 888-393-2789.

(c) *Order of Benefit Determination:* Expenses eligible for coverage under any medical, dental, or vision care plan in which the Participant or Participant Dependent is enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Administrator for reimbursement under the IMEHRA.

Claims will be paid in the order in which they are filed and will be charged to the IMEHRA Account of the Participant who incurred the expense on behalf of himself or his Participant Dependent. The Administrator may establish such other rules as it deems appropriate regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement, and the maximum amount available for reimbursement during any single month.

(d) *Claims Denied*: Claims that are partially or wholly denied may be appealed as provided in Section 6.2.

5.6 Spend-Down Period

Upon the cessation of participation as provided in section 3.2, a Participant or Participant Dependent may incur Qualifying Eligible Medical Expenses for a period of two (2) months after cessation of participation, and be reimbursed from the ~~this~~ IMEHRA. Reimbursement shall be limited to the unused balance in the Participant's Account. At the end of the Spend-Down Period and Run-Out Period, any unused Benefit balance in the Participant's Account shall be forfeited.

5.7 Run-Out Period

Participants may submit Qualifying Eligible Medical Expenses incurred during the preceding Plan Year and/or the Spend-Down Period for reimbursement from their

IMEHRA Accounts no later than two (2) months after the Spend-Down Period. Reimbursement shall be limited to the unused balance in the Participant's IMEHRA Account.

In the event that the Participant dies, and he has no Participant Dependent, or the Participant Dependent fails to elect COBRA IMEHRA coverage timely, then the Participant's IMEHRA Account balance shall be forfeited unless his estate or representative submits claims for Qualifying Eligible Medical Expenses incurred after he was participating in this IMEHRA and prior to his death, as long as such claims are submitted no later than six (6) months after the Participant's death, limited to the unused balance in the Participant's IMEHRA Account. If the surviving Participant Dependent elects COBRA IMEHRA coverage, then reimbursement shall be governed by Section 5.9.

5.8 Carryover of Accounts

To the extent any balance remains in the Participant's IMEHRA Account for a Plan Year after all reimbursements have been made for the Plan Year, such balance shall be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during a subsequent Plan Year. However, upon the cessation of participation under Section 3.2, the Participant may incur claims during the Spend-Down Period. Expenses incurred after the end of the Spend-Down Period will not be reimbursed, and any unused balance in the Participant's IMEHRA Account after the Run-Out Period shall be forfeited under Section 5.10.

5.9 COBRA Continuation Coverage

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and Participant Dependent (Qualified Beneficiaries), whose coverage terminates under the IMEHRA Account because of a COBRA Qualifying Event, shall be given the opportunity to continue the same coverage that he had under the IMEHRA Account on the day before the Qualifying Event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date the continuation coverage is selected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants.

At the beginning of each month in the Plan Year, Qualified Beneficiaries shall be credited with the monthly reimbursement accrual (i.e., the maximum annual reimbursement amount, divided by the number of months in that Plan Year) that is made available to similarly situated non-COBRA beneficiaries, and any unused reimbursement amounts from the previous Plan Year shall be carried over to the next Plan Year. An administrative fee for COBRA continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Administrator and permitted by COBRA.

5.10 Forfeiture of Accounts

If after the cessation of participation under Section 3.2, a Participant has a positive (greater than $0) balance in his IMEHRA Account once all reimbursements for Qualifying Medical Care Expenses of the Participant or Participant's Dependent have been made for the Plan Year and/or the Spend-Down Period, all rights with respect to such balance shall be forfeited unless the Participant or Participant Dependent elects COBRA continuation coverage under Section 5.9.

Article 6
APPEALS PROCEDURE

6.1 Denial of Participation or Reimbursement

(a) *Denial of Participation.* If participation in the IMEHRA is denied, notice of the decision shall be furnished to the applicant within a reasonable period of time, not to exceed thirty (30) days after receipt of the Enrollment Form by the Administrator unless special circumstances due to matters beyond the control of the plan require an extension of time for processing the Enrollment Form. If such an extension is required, written notice of the extension shall be furnished to the applicant prior to the termination of the initial thirty (30) days after receipt of the Enrollment Form. The extension shall indicate the special circumstances requiring the extension of time.

(b) *Denial of Reimbursement.* If a claim for reimbursement under the IMEHRA is wholly or partially denied, notice of the decision shall be furnished to the Participant within a reasonable period of time, not to exceed thirty (30) days after receipt of the claim by the Administrator unless special circumstances due to matters beyond the control of the plan require an extension of time for processing the claim. If an extension is necessary, the claimant shall be notified within the initial thirty (30) day period that an additional fifteen (15) days is needed to review the claim. When an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information the claimant will need to provide. The claimant will have no less than forty-five (45) days from the date he receives the notice to provide the requested information.

(c) *Notice of Denial.* A written notice shall be sent for each denied claim and shall set forth the following:

(1) The specific reason or reasons for the denial;

(2) The specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to correct the claim and an explanation of why such material or information is necessary;

(4) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the

appeal determination and that a copy of such rule will be provided to the claimant free of charge upon request; and

(5) A description of the IMEHRA's appeal procedures and the time limits applicable to such procedures, including contact information for member assistance provided by the Administrator and contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT), 888-393-2789, as set forth in this Article 6.

6.2 Appeals

The purpose of the review procedure as set forth herein is to provide a procedure by which a denial under the IMEHRA may receive a full and fair review by the Appeals Panel. To obtain this review, one shall submit a written request for a review by Appeals Panel with the Administrator within one hundred eighty (180) days of the date of the written notice of the denial. In connection with this request for review, the appellant may review pertinent plan documents and submit issues and/or comments in writing to the Administrator.

6.3 Decision on Review

Decisions on review shall be made in the following manner:

(a) The decision on review shall be made by the Appeals Panel. The Appeals Panel shall make its decision promptly, and not later than sixty (60) days after the Appeals Panel receives the request for review, unless special circumstances due to matters beyond control of the plan require extension of time for processing. In such case, a decision shall be rendered as soon as possible, but not later than seventy-five (75) days after receipt of the request for review. If such an extension of time for review is required, written notice of the extension shall be furnished to the Participant prior to the commencement of the extension.

(b) The decision on review shall be in writing and shall include specific reasons for the decision.

In the event that the decision on review is not furnished within the time period set forth in this Section 6.3, the claim shall be deemed denied on review.

ARTICLE 7
HIPAA

7.1 **Purpose.** This Article permits the Administrator to disclose PHI to the Individual Market Medicare Exchange to the extent that such PHI is necessary for the Individual Market Medicare Exchange to carry out its administrative functions related to the IMEHRA. This Article reflects the requirements set forth in 45 CFR § 164.504(f) of HIPAA and the related regulations promulgated by the U.S. Department of Health and Human Services. Any term used in this Article 7 shall have the meaning set forth in HIPAA and guidance issued thereunder.

7.2 **HIPAA Privacy Compliance.**

(a) *Disclosures to the Individual Market Medicare Exchange.* In accordance with HIPAA, the Administrator may disclose summary health information to the Individual Market Medicare Exchange as requested by the Individual Market Medicare Exchange to allow it to modify, amend or terminate, or obtain premium bids from insurers to provide health insurance coverage under the Individual Market Medicare Exchange. The Individual Market Medicare Exchange may disclose to the Administrator information on whether an individual is participating or enrolled in the IMEHRA. In addition, the Administrator may disclose protected health information to the Individual Market Medicare Exchange as necessary to allow the Individual Market Medicare Exchange to perform plan administration functions, as used within the meaning of the HIPAA privacy regulations, including the following functions:

(1) Collection of Individual Medicare Plan premiums;

(2) Conducting quality assessment and improvement activities, population – based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions;

(3) Reviewing health plan performance;

(4) Activities relating to obtaining or renewing health insurance or determining premium pricing for such benefits, or placing a contract for reinsurance of risk relating to such claims;

(5) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development of the Individual Market Medicare Exchange, such as conducting cost-management and planning-related

analyses, including formulary development and administration, development or improvement of methods of payment or coverage policies;

(7) Business management and general administrative activities of the Individual Market Medicare Exchange;

(8) Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;

(9) Billing, claims management, collection activities, obtaining payment under a stop-loss contract, and related health care data processing;

(10) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

(11) Utilization review activities;

(12) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:
(A) Name and address;
(B) Date of birth;
(C) Social security number;
(D) Payment history;
(E) Account number; and
(F) Name and address of the health care provider and/or health plan.

(13) Risk adjusting amounts due to enrollee health status and demographic characteristics.

(b) *Access to Medical Information.* The following employees or individuals under the control of the Individual Market Medicare Exchange shall have access to the Administrator's protected health information to be used solely for the purposes described above:

(1) Employees of the Individual Market Medicare Exchange; and

(2) Such other classes of individuals identified by the Administrator's Privacy Officer as necessary for the Individual Market Medicare Exchange's administration.

(c) *The Individual Market Medicare Exchange Agreement to Restrictions.* The Individual Market Medicare Exchange agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Report any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which the Individual Market Medicare Exchange becomes aware;

(3) Make protected health information accessible to the subject individual in accordance with 45 CFR § 164.524;

(4) Allow the subject individuals to amend or correct their protected health information in accordance with 45 CFR § 164.526;

(5) Make available the information to provide an accounting of its disclosures of protected health information in accordance with 45CFR § 164.528;

(6) Make its internal practices, books and records available to the Secretary of Health and Human Services for determining compliance;

(7) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses as required by 45 CFR § 164.504(f)(2)(ii)(I);

(8) Ensure that any agents, including a subcontractor, of the Individual Market Medicare Exchange to whom the Individual Market Medicare Exchange provides protected health information shall also agree to these same restrictions;

(9) Restrict access to protected health information to those classes of employees or individuals identified above; and

(10) Restrict the use of protected health information by those employees identified above for plan administration functions within the meaning at 45 CFR § 164.504(a).

(d) *Noncompliance Resolution.* In the event of noncompliance with the above restrictions by a designated employee or other individual receiving protected health information on behalf of the Individual Market Medicare Exchange , the employee or other individual shall be subject to discipline in accordance with the Individual Market Medicare Exchange 's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Individual Market Medicare Exchange Privacy Offical and the Administrator 's Privacy Official.

7.3 **HIPAA Security Compliance.**

(a) *The Individual Market Medicare Exchange Obligations.* The Individual Market Medicare Exchange shall do the following:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the IMEHRA;

(2) Ensure that the adequate separation required by 45 CFR §64.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information;

(4) Report any security incident of which it becomes aware;

(5) Make the Individual Market Medicare Exchange's internal practices, books, and records relating to security of electronic PHI received from the Administrator available to the Secretary of Health and Human Services (or any other officer or employee of the U.S. Department of Health and Human Services to whom the authority involved has been delegated) for purposes of determining compliance by the Individual Market Medicare Exchange with the HIPAA security standards.

Article 8
ADMINISTRATION

8.1 Administrator

The administration of the IMEHRA shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that the terms of this IMEHRA are carried out, in accordance with the terms of this Plan Document, for the exclusive benefit of persons entitled to participate in this IMEHRA without discrimination among them.

8.2 Powers of the Administrator

The Administrator shall have such duties and powers, as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan Document, including all possible ambiguities, inconsistencies and omissions in the Plan Document and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this IMEHRA (provided that, notwithstanding the first paragraph in this Section 7.2, the Appeals Panel shall exercise such exclusive power with respect to an appeal under Article 6);

(b) to prescribe procedures to be followed and the forms to be used to make elections pursuant to this IMEHRA;

(c) to prepare and distribute information explaining this IMEHRA and the Benefits under this IMEHRA in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Participants such information as the Administrator shall determine from time to time to be necessary for the proper administration of this IMEHRA;

(e) to furnish each Participant with such reports with respect to the administration of this IMEHRA as the Administrator determines to be reasonable and appropriate;

(f) to receive, review and keep on file such reports and information concerning the Benefits covered by this IMEHRA as the Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this IMEHRA as it determines to be necessary or advisable;

(h) to sign documents for the purpose of administering this IMEHRA, or to designate an individual or individuals to sign documents for the purposes of administering this IMEHRA; and

(i) to maintain the books of accounts, records, and other data in the manner necessary for the proper administration of this IMEHRA and to meet any applicable disclosure and reporting requirements.

The Administrator shall have no power to alter the terms of this Plan Document or to waive or fail to apply requirements governing eligibility or participation.

8.3 Reliance on Participant, Tables, etc.

The Administrator may rely upon the direction, information or election of a Participant as being proper under the IMEHRA and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

8.4 Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or failure to act except for his own willful misconduct or willful breach of this IMEHRA.

8.5 Inability to Locate Payee

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under this IMEHRA because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited sixty (60) days after the end of **the claim** Run-Out Period.

8.6 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the Account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent it deems possible and permissible under the Code or the regulations

issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the Account or distributions to which he is properly entitled under this IMEHRA. Such action by the Administrator may include withholding of any amounts due this IMEHRA.

Article 9
GENERAL PROVISIONS

9.1 Expenses

All reasonable expenses incurred in administering the IMEHRA are currently paid by the Office of Group Benefits, Division of Administration, State of Louisiana and by forfeitures to the extent provided in Section 5.10.

9.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Participant and the Employer to the effect that such Participant.

9.3 Amendment and Termination

This IMEHRA has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Administrator may amend or terminate this IMEHRA at any time by direction of the Office of Group Benefits, or by any person or persons authorized by the Office of Group Benefits to take such action, and any such amendment or termination will automatically apply to the related Employers which are participating in this IMEHRA. This reserved right to amend includes but is not limited to the right to modify persons eligible for participation, benefits paid by the Plan, the amount of Employer contributions, and the right to reduce or eliminate existing HRA Accounts.

9.4 Governing Law

This IMEHRA shall be construed, administered, and enforced according to the laws of the State of Louisiana, to the extent not superseded by the Code, or other federal law.

9.5 Code Compliance

It is intended that this IMEHRA meets all applicable requirements of the Code, and all of the regulations issued thereunder. This IMEHRA shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan Document and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause, or provision of this Plan Document shall be deemed superseded to the extent of the conflict.

9.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this IMEHRA will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this IMEHRA is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable. By accepting a benefit under this Plan, each Participant agrees to be liable for any tax that may be imposed with respect to any amounts paid to or for the benefit of a Participant under this IMEHRA, plus any interest as may be imposed.

9.7 Indemnification of Employer

If a Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

9.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this IMEHRA shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever to be recognized, except to such extent as may be required by law.

9.9 National Medical Support Notices (NMSNs)/Qualified medical Child Support Orders (QMCSOs)

In the event the Administrator receives a NMSN, the Administrator shall notify the affected Participant and any alternate recipient indentified in the order of receipt of the order and the Plan's procedures for determining whether such an order is appropriately completed and deemed to be a QMCSO. Within a reasonable period, the Administrator shall determine whether the NMSN is deemed to be a QMCSO and shall notify the Participant and alternate recipient of such determination. This IMEHRA will provide Benefits in accordance with the applicable requirements of any NMSN, even if the child does not meet the definition of "Dependent."

9.10 Plan Document Provisions Controlling

In the event the terms or provisions of any summary or description of this IMEHRA, or of any other instrument, are in any construction interpreted as being

in conflict with the provisions of this Plan Document as herein set forth, the provisions of this Plan Document shall be controlling.

9.11 Severability

In the event any provision of this Plan Document shall be held illegal or invalid for any reason, this illegality or invalidity shall not affect the remaining provisions of this Plan Document, and such remaining provisions shall be fully severable and this Plan Document shall, to the extent practicable, be construed and enforced as if the illegal or invalid provision had never been inserted therein.