

# **UnitedHealthcare Insurance Company**

## **Group Policy**

**For**

**HRI Properties, LLC**

**Enrolling Group Number: 904042**

**Policy Effective Date: January 1, 2025**



# Group Policy

## UnitedHealthcare Insurance Company

185 Asylum Street  
Hartford, Connecticut 06103-0450  
877-294-1429

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

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

Upon our receipt of the signed Group *Application* and payment of the first Policy Charge, this Policy is executed. The Group's *Application* is made a part of this Policy.

We agree to provide Benefits for Covered Health Care Services stated in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Care Services between the Group and us. The terms and conditions of this Policy will in turn be overruled by those of any future agreements relating to Benefits for Covered Health Care Services between the Group and us.

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

This Policy is effective on the date shown in Exhibit 1 and continues in force by the timely payment of the required Policy Charges when due, subject to the end of this Policy as provided in Article 5.

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

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company



Jessica Paik, President

## Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings as those defined in *Section 9: Defined Terms* in the attached *Certificate(s) of Coverage*. In addition, the following terms apply:

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

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

## Article 2: Benefits

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

## Article 3: Premium Rates and Policy Charge

### 3.1 Premiums

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

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

### 3.2 How Is the Policy Charge Calculated?

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

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

### 3.3 When Is the Policy Charge Adjusted?

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

The Group must notify us in writing, through our electronic systems, or by other methods as determined by us within 60 days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing, through our electronic systems, or by other methods as determined by us each month of any change in the Coverage Classification for any Subscriber.

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

### **3.4 How Is the Policy Charge Paid?**

The Policy Charge is payable to us in advance by the Group as described under "Payment of the Policy Charge" in Exhibit 1. The Group agrees to remit to us the Policy Charge due which is based on our enrollment records as provided by the Group at the time the invoice for the Policy Charge is issued. The first Policy Charge is due and payable on or before the effective date of this Policy. Future Policy Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Policy is in force. If the Policy Charge remains unpaid, the Policy will end as described below under *5.1 When Does the Policy End?*

All payments shall be made in United States currency, in immediately available funds, and shall be sent to us at the address on the invoice, or at another address that we may designate in writing. The Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Group will remain obligated to pay any and all amounts owed to us.

Late payment charges are assessed for any Policy Charge not received within 10 calendar days following the due date. There will be a service charge added to the Group's account for any check returned for non-sufficient funds.

The Group will reimburse any attorney's fees and costs related to collecting past due Policy Charges.

### **3.5 Does a Grace Period Apply?**

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

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

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

## **Article 4: Eligibility and Enrollment**

### **4.1 What Are the Eligibility Rules?**

The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Policy. The eligibility rules must be applied consistently and can be found in this Policy, Group *Application*, and within the *Certificate of Coverage*.

### **4.2 Initial Enrollment Period**

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

### **4.3 Open Enrollment Period**

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

#### **4.4 Effective Date of Coverage**

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

### **Article 5: End of Policy**

#### **5.1 When Does the Policy End?**

This Policy and all Benefits for Covered Health Care Services will automatically end on the earliest of the dates shown below:

- A. At our option, retroactive to the last paid date of coverage if the grace period expires and the Policy Charge remains unpaid on the due date.
- B. On the date specified by the Group, after at least 31 days prior written notice to us that this Policy will end.
- C. On the date we specify, after at least 60 days prior written notice to the Group, that this Policy will end due to the Group's violation of the participation rule contribution rule participation and contribution rules as shown in Exhibit 1.
- D. On the date we specify, after at least 60 days prior written notice to the Group, that this Policy will end because the Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:
  - The effective date of this Policy.
  - The date of the act, practice or omission, if later.
- E. On the date we specify, after at least 90 days prior written notice to the Group, that this Policy will end because we will no longer issue this particular type of group health benefit plan within the applicable market.
- F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Group, that this Policy will end because we will no longer issue any employer health benefit plan within the applicable market.

#### **5.2 Payment When the Policy Ends**

When the Policy ends, the Group is and will remain responsible to us for the payment of any and all Premiums which are unpaid at the time the Policy ends. This will include a pro rata portion of the Policy Charge for any period this Policy was in force during any grace period preceding the end of the Policy.

### **Article 6: General Provisions**

#### **6.1 What Is the Entire Policy?**

This Policy, the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the *Group Application*, and any Amendments, *Notices of Change*, and Riders, make up the entire Policy.

#### **6.2 Dispute Resolution**

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as noted below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Group wishes to seek further review of the dispute, it must submit the dispute to binding arbitration according to the rules of the *American Arbitration Association*. This is the only right the Group has for further consideration of any dispute that arises out of or is related to this Policy.

Arbitration will take place in Hartford County, Connecticut.

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

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

### **6.3 Time Limit on Certain Defenses**

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

### **6.4 Amendments and Alterations**

Amendments and Riders to this Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law. Other than changes to Exhibit 2 stated in a *Notice of Change* to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers and consistent with applicable notice requirements. No agent has authority to change this Policy or to waive any of its provisions.

### **6.5 Our Relationship with Providers and Groups**

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

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

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

#### **Louisiana Notice**

YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

### **6.6 Records**

We may require information related to the Policy, from the Group. Upon request, the Group must provide us with the requested information and proofs which may include:

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

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

We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are needed to administer the terms of this Policy including records for appropriate medical and quality review or as required by law or regulation.

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

## **6.7 Administrative Services**

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

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

## **6.8 Employee Retirement Income Security Act (ERISA)**

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

## **6.9 Do We Require Examination of Covered Persons?**

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

## **6.10 What Happens When There Is a Clerical Error?**

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments is not a clerical error. We will not provide retroactive coverage for Eligible Persons when the Group fails to report enrollments. Failure to report the end of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to end. Upon discovery of a clerical error, any needed adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

## **6.11 Is Workers' Compensation Affected?**

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

## **6.12 Conformity with Law**

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

### **6.13 Notice**

We provide written notice regarding Policy administration to the Group's authorized representative. Once delivered, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to Covered Persons on a timely basis.

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

### **6.14 Continuation Coverage**

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

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

### **6.15 Subscriber's Individual Certificate**

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Group for delivery to each Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* may be available online at [www.myuhc.com](http://www.myuhc.com).

### **6.16 Summary of Benefits and Coverage**

We will provide a *Summary of Benefits and Coverage* ("SBC"), as required by the *Affordable Care Act* and related regulations ("ACA"), to the Group for each benefit plan purchased. The Group is responsible for delivering the SBC to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the ACA.

### **6.17 System Access**

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

#### **System Access**

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

The Group will not:

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

The Group may designate a third party access to the systems on its behalf, provided the third party agrees to these terms and conditions. The Group remains responsible for the third party's compliance with the entire *System Access* provision.

### **Security Procedures**

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

### **End of System Access**

We have the right to end the Group's system access:

- On the date the Group does not accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon the date this Policy ends, the Group agrees to cease all use of systems, and we will deactivate the Group's identification numbers and passwords and access to the system.

# Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and HRI Properties, LLC, the Group.
2. **Effective Date.** The effective date of this Policy is 12:01 a.m. on January 1, 2025 in the time zone of the Group's location.
3. **Place of Issuance.** We are issuing this Policy in Louisiana and reserve the right to review place of issuance determinations. The Policy is subject to the laws of the state of Louisiana and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Louisiana law governs this Policy.
4. **Premiums.** We have the right to change the *Schedule of Premium Rates* shown in each Exhibit 2, after a 45-day prior written notice at any time.
5. **Computation of Policy Charge.** A full month's Premium will be charged for any Covered Person who is covered under this Policy for any portion of a calendar month.
6. **Payment of the Policy Charge.** The Policy Charge is payable to us in advance by the Group on a monthly basis.
7. **Minimum Participation Requirement.** 50% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.
8. **Minimum Contribution Requirement.** The Group must maintain a minimum contribution requirement of 85% of the Premium for each Eligible Person.
9. **Notice.** Any notice sent to us under this Policy must be sent to:  
UnitedHealthcare Insurance Company  
185 Asylum Street  
Hartford, Connecticut 06103-0450  
Any notice sent to the Group under this Policy must be sent to:  
HRI Properties, LLC  
812 Gravier St., Suite 200  
New Orleans, Louisiana 70112
10. 904042: Group Number

## Exhibit 2 Class 1

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

1. **Class Description.**

All Employees enrolled in UnitedHealthcare Choice Plus Plan DUEX.

2. **Eligibility.** The eligibility rules are applied by the Group. The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Policy. In addition to the requirements below, the eligibility rules can be found in this Policy, Group *Application*, and within the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows: 30 days

B. Notwithstanding the eligibility rules for health plan participation, continued coverage under this Policy for a Covered Person on a leave of absence (LOA) will be available in accordance with the following, unless state, local or federal law requires a longer period of time:

- ♦ For a Covered Person on a non-medical LOA, coverage will be available for no longer than 13 consecutive weeks from the beginning of the LOA.
- ♦ For a Covered Person on a medical LOA, coverage will be available for no longer than 26 consecutive weeks from the beginning of the LOA.

C. Minimum required hours per week as outlined in the Group *Application* or as agreed to by the Group and us, and as required by applicable law.

D. Other:

None

3. **Open Enrollment Period.** An Open Enrollment Period of at least 60 days will be provided by the Group when Eligible Persons may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2025.

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

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2025 is shown below:

Coverage Classification	Monthly Premium
Subscriber only	\$886.05
Subscriber and spouse	\$1,860.71
Subscriber plus one child	\$1,639.18
Subscriber plus family	\$2,569.54

## Exhibit 2 Class 2

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

1. **Class Description.**

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

2. **Eligibility.** The eligibility rules are applied by the Group. The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Policy. In addition to the requirements below, the eligibility rules can be found in this Policy, Group *Application*, and within the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows: 30 days

B. Notwithstanding the eligibility rules for health plan participation, continued coverage under this Policy for a Covered Person on a leave of absence (LOA) will be available in accordance with the following, unless state, local or federal law requires a longer period of time:

- ♦ For a Covered Person on a non-medical LOA, coverage will be available for no longer than 13 consecutive weeks from the beginning of the LOA.
- ♦ For a Covered Person on a medical LOA, coverage will be available for no longer than 26 consecutive weeks from the beginning of the LOA.

C. Minimum required hours per week as outlined in the Group *Application* or as agreed to by the Group and us, and as required by applicable law.

D. Other:

None

3. **Open Enrollment Period.** An Open Enrollment Period of at least 60 days will be provided by the Group when Eligible Persons may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2025.

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

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2025 is shown below:

Coverage Classification	Monthly Premium
Subscriber only	\$722.24
Subscriber and spouse	\$1,516.69
Subscriber plus one child	\$1,336.16
Subscriber plus family	\$2,094.51

## Rider 3 - Advocate4Me<sup>SM</sup>

### UnitedHealthcare Insurance Company

The Group agrees to take part in an advocate-based consumer experience program. This program provides Subscribers and Enrolled Dependents with an additional level of support services.

For the purpose of this Exhibit, "advocate" means representatives that are a part of the Advocate4Me program.

Advocate4Me provides the following enhanced levels of support:

- **Expert Advocate Support** - Provides a point of contact to answer questions. This contact will address and resolve issues, and engage in clinical programs.
- **Integrated Financial Support** - The ability for the advocate to address simple financial questions in advance and in connection with *Optum Bank*. This includes questions on balances, last transactions and enrollment.
- **Elevated Issue Resolution** - Provide enhanced issue resolution. This includes escalation to experts to address issues in reduced timeframes.
- **Consumer Preference Communication** - Offer communication across technologies. This includes email, fax and telephone.

UnitedHealthcare Insurance Company



Jessica Paik, President

## **Rider 4 - Policy Charge Waiver**

### **UnitedHealthcare Insurance Company**

We may not collect an amount of up to one month's Policy Charge during any Policy year.

This Policy Charge waiver is for the purpose of compensating the Group for either:

- Offsetting the transition costs when moving from another carrier to us. These transition costs include programming changes to Benefit administration systems and employee communications regarding Benefit program changes.
- Achieving your annual health care plan budget goals without reducing Benefit levels or increasing required contributions for your Subscribers.

The Policy Charge waiver will not apply for Subscribers that were added or removed from the Policy after we billed the Group for that month's Policy Charge. For that month of coverage, additional Premium will be due or credited for those Subscribers.

UnitedHealthcare Insurance Company

A handwritten signature in cursive script that reads "Jessica Paik".

Jessica Paik, President

# **Amendment**

## **Policy Charge Credit for UnitedHealthcare Rewards Engagement**

The Group may be eligible for a Policy Charge credit when both of the following are met:

- The Group renews their Policy with us; and
- The Group meets annual engagement requirements based on completion of activity targets which are described in the UnitedHealthcare Rewards Rider.

The Policy Charge credit will be applied to the Policy Charge, as applicable, administered by us.

UnitedHealthcare Insurance Company

A handwritten signature in cursive script that reads "Jessica Paik".

Jessica Paik, President

# Summary of the Louisiana Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

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

Except as provided in R.S. 22:2098(D), when an insurer delivers a policy or contract described in R.S. 22:2083(B)(1), then prior to or at the time of delivery, the disclaimer notice described in R.S. 22:2098(C) and approved by the commissioner, shall be given separately to the policy or contract holder:

## Disclaimer

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

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

### LLHIGA

PO Drawer 44126  
Baton Rouge, LA 70804

### Department of Insurance

PO Box 94214  
Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law) and is set forth at R.S. 22:2081 et seq. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

## Exclusions from Coverage

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

- he is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state; or
- his policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- dividends, premium refunds, or similar fees or allowances described under the law;
- credits given in connection with the administration of a policy by a group contract holder;
- employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured; or
- unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. § 403(b));
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to " Medicare Part C coverage " or " Medicare Part D coverage " and any regulations issued pursuant to those parts;
- interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

## **Limits on Amounts of Coverage**

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out.

The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

- LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.

- For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance.
- For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of \$500,000 in health insurance benefits, and LLHIGA will pay a maximum of \$250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than \$500,000 in the aggregate with respect to any one individual.





