

STATE OF LOUISIANA



PPO Plan Document

January 1, 2012

PREFERRED PROVIDER ORGANIZATION PLAN DOCUMENT
January 1, 2012

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General Plan Information

Office of Group Benefits
(Herein called the Program)

Group Coverage: Self-insured and self-funded medical

EMPLOYER INFORMATION: Governmental agencies of the State of Louisiana
(herein called Participant Employers)

Group Contract Issuer: Office of Group Benefits

Effective Date: January 1, 2012

This contract is between the Participant Employer and the Office of Group Benefits. It shall be construed in accordance with the laws of the State of Louisiana.

The program is entitled to rely upon the signature of the designated representatives of each Participant Employer for the Participant Employer as to any and all matters pertaining to this contract.

In consideration of the payment of premiums by the Participating Employer, the Program hereby agrees with the employer, subject to the terms appearing on this and the following pages of this contract as amended to pay benefits in accordance with the terms of this contract.

The obligations and the rights of all persons under this contract shall be determined in accordance with the terms of this contract without regard to the terms of any prior agreement or of any instrument amending or supplementing or replacing any such agreement.

SCHEDULE OF BENEFITS – PPO

Eligible Expenses are reimbursed in accordance with a Fee Schedule of maximum allowable charges.

ALL ELIGIBLE EXPENSES ARE DETERMINED IN ACCORDANCE WITH PLAN LIMITATIONS AND EXCLUSIONS.

COMPREHENSIVE MEDICAL BENEFITS

Deductibles

Inpatient deductible per day, maximum of five days per admission (waived for admissions at participating hospitals)	\$ 50
Emergency room charges for each visit, unless the Covered Person is hospitalized immediately following emergency room treatment (prior to and in addition to Plan Year deductible)	\$ 150
Professional and other Eligible Expenses, Active Employees and Dependents of Employees	\$500 per person, per Plan Year
Professional and other Eligible Expenses, Retirees and Dependents of Retirees	\$300 per person, per Plan Year
Family Unit maximum	3 individual deductibles

Percentage Payable after Satisfaction of Applicable Deductibles

Eligible Expenses incurred for services of a participating Provider	90%
Eligible Expenses incurred for services of a non-participating Provider when Plan Member resides outside of Louisiana	90%
Eligible Expenses incurred for services of a non-participating Provider when Plan Member resides in Louisiana	70%
Eligible Expenses incurred when Medicare or other group health plan is primary, after Medicare deduction	80%
Eligible Expenses in excess of \$10,000 per Plan Year, per person	100%

- **Eligible Expenses of a PPO are based upon contracted rates. PPO discounts are not Eligible Expenses and do not apply to the \$10,000 threshold.**
- **Eligible Expenses of non-participating providers are based upon the OGB's Fee Schedule. Charges in excess of the Fee Schedule are not Eligible Expenses and do not apply to the \$10,000 threshold.**

There may be a significant out-of-pocket expense to the Plan Member when using a non-participating Provider.

Although your Hospital or Physician may be participating Providers, they may recommend, use, or make a referral to other non-participating Providers. These ancillary Providers will be paid at 70% of Eligible Expenses.

DENTAL SURGERY BENEFIT FOR SPECIFIED PROCEDURE

Percentage payable (Not subject to Plan Year deductible)	100%
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PRESCRIPTION DRUGS

(Not subject to deductible)

Network Pharmacy

Member pays 50% of drug costs at point of purchase

Maximum co-payment

\$50 per 30-day prescription dispensed

Out-of-pocket threshold

\$1200, per person, per Plan Year

Co-pay after threshold is reached

Brand – \$15, Generic – No co-pay
(Plan pays balance of Eligible Expenses)

Non-network pharmacy

Member pays full drug costs at point of purchase

In-state

Reimbursement limited to 50% of amount payable by Plan at Network Pharmacy

Out-of-state

Reimbursement limited to 80% of amount payable by Plan at Network Pharmacy

Note: Beginning January 1, 2006, a new Medicare prescription drug plan became available to all Medicare recipients. OGB's Plan coverage provides benefits that are on average as good as or better than Medicare Part D.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage.

See page 42 for details.

PREVENTIVE CARE

Preventive Care Services rendered by Participating Providers are reimbursed at 100% of Eligible Expenses, as provided in the Affordable care Act.;

Preventive Care Services rendered by Non-participating Providers are subject to applicable deductibles and are reimbursed at 70% of Eligible Expenses.

Services include screenings to detect illness or health risks during a Physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history.

Specialized age appropriate wellness – For a complete list of benefits, see Article 3, Section I (A) 24.

DURABLE MEDICAL EQUIPMENT

Percentage Payable

See percentage payable after deductible – Page 5

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Deductibles

Subject to and combined with the Medical Deductibles set forth above.

Percentage of Eligible Expenses Payable after Satisfaction of Deductibles

	In-Network (Participating) Providers	Out-of-Network (Non-Participating) Providers
Inpatient Treatment ¹	90%	70%
Outpatient Treatment	90%	70%

¹ Prior authorization required for inpatient treatment.

DEFINITIONS

Accidental Injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

Affordable Care Act means the Patient Protection and Affordable Care Act, a United States federal statute signed into law on March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, and other amending laws, as well as regulations validly promulgated pursuant thereto.

Appeal means a request by a plan member for and a formal review of a medical claim for benefits or an eligibility determination.

Autism Spectrum Disorders (ASD) means any of the pervasive development disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C. (DSM), including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Benefit Payment means payment of Eligible Expenses due or owing by a Covered Person, after applicable deductibles, co-payments, and coinsurance, and subject to all limitations and exclusions, at the rate shown under Percentage Payable in the Schedule of Benefits.

Brand Drug means the trademark name of a drug approved by the U. S. Food and Drug Administration.

CEO means the Chief Executive Officer of the Program.

Child or Children includes:

1. A Child of the Employee and/or the Employee's legal spouse;
2. A Child in the process of being adopted by the Employee through an agency adoption;
3. A Child under the guardianship or in the legal custody of the Employee;
4. A Grandchild of the Employee who is not in the legal custody of the Employee whose parent is a covered Dependent. If the Employee seeking to cover a Grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

Note: If the Employee Dependent parent becomes ineligible for coverage under the Program, the Employee's Grandchild will also be ineligible for coverage, unless the Employee has legal custody of his/her Grandchild.

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

Convalescent /maintenance care or rest cure means treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by one's self, family, or other caregivers who are not eligible Providers. The services are primarily designed to help the patient with daily living activities, maintain the patient's present physical and mental condition, and/or provide a structured or safe environment.

Covered Person means an active or retired Employee, his/her eligible Dependent, or any other individual eligible for coverage for whom the necessary application forms have been completed and for whom the required contribution is made.

Covered Services refers to those health care services for which a Plan Member is entitled to receive Benefit Payments in accordance with the terms of this Plan.

Custodial Care means:

1. Care designed to assist an individual in the performance of daily living activities (i.e. services which constitute personal care such as walking, getting in and out of bed, bathing, dressing, eating, and using the toilet) that does not require admission to a hospital or other institution for the treatment of a disease, illness, accident, or injury, or for the performance of surgery;
2. Care primarily intended to provide room and board to an individual with or without routine nursing care, training in personal hygiene, or other forms of self-care;
3. Supervisory care provided by a Physician whose patient is mentally or physically incapacitated and is not under specific medical, surgical, or psychiatric treatment, when such care is intended to reduce the patient's incapacity to the extent necessary to enable the patient to live outside of an institution providing medical care, or when, despite treatment, there is not a reasonable likelihood that the incapacity will be reduced.

Date Acquired means the date a Dependent of a covered Employee is acquired in the following instance and on the following dates only:

1. Legal Spouse – the date of marriage;
2. Child or Children –
 - a. Natural Children – the date of birth;
 - b. Children in the process of being adopted:
 - Agency adoption – the date the adoption contract was executed between the Employee and the adoption agency;
 - Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee. The Program must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;
 - c. Child for whom the Employee has legal custody or guardianship – the date of the court order granting legal custody or guardianship or of the notarized act granting provisional custody;
 - d. Grandchild of the Employee who is not in the legal custody of the Employee whose parent is a covered Dependent:
 - i. The date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or
 - ii. The date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

Deductible means the dollar amount that a Covered Person must pay as shown in the Schedule of Benefits before benefits will be paid in a Plan Year.

Dependent – any of the following persons who (a) are enrolled for coverage as Dependents by completing appropriate enrollment documents, if they are not also covered as an Employee, and (b) whose relationship to the Employee has been Documented, as defined herein:

1. The covered Employee's legal Spouse;

2. A Child from date acquired until attainment of age 26;

3. A Child of any age who meets the criteria set forth in Article 1 Section II (D) herein.

Dependent Coverage means Plan benefits with respect to the Employee's Dependent(s) only.

Disability means that the Covered Person, if an Employee, is prevented, solely because of a disease, illness, accident, or injury, from engaging in his or her regular or customary occupation and is performing no work of any kind for compensation or profit; or, if a Dependent is prevented from substantially engaging in all the normal activities of a person of like age in good health solely because of a disease, illness, accident, or injury.

Documented (with respect to a Dependent of an Employee) – the following written proof of relationship to the Employee has been presented for inspection and copying to OGB, or to a representative of the Employee's Participant Employer designated by OGB:

1. The covered Employee's legal Spouse - Certified copy of certificate of marriage indicating date and place of marriage;

2. Child:
 - a. Natural or legally adopted child of plan member - Certified copy of birth certificate listing plan member as parent or certified copy of legal acknowledgment of paternity signed by plan member or certified copy of adoption decree naming plan member as adoptive parent;

 - b. Stepchild - Certified copy of certificate of marriage to spouse and birth certificate listing spouse as natural or adoptive parent;

 - c. Child placed with your family for adoption by agency adoption or irrevocable act of surrender for private adoption - Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender;

 - d. Child for whom you have been granted guardianship or legal custody, including provisional custody, - Certified copy of signed the court order granting legal guardianship or custody, or the original notarized act granting provisional custody in proper statutory form and substance;

 - e. Grandchild for whom you do not have legal custody or guardianship whose parent is a covered dependent - Certified birth certificate or adoption decree showing parent of grandchild is dependent child and certified copy of birth certificate showing dependent child is parent of grandchild;

3. Child age 26 or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age 26 - Documentation as described in 2a through 2d above together with an application for continued coverage supporting medical documentation prior to the child's attainment of age 26 as well as additional medical documentation of child's continuing condition periodically upon request by OGB;

4. Such other written proof of relationship to the Employee deemed sufficient by OGB.

Durable Medical Equipment (DME) means equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of an illness or injury, and is appropriate for use in the home. DME includes, but is not limited to, items such as wheelchairs, hospital beds, respirators, braces (non-dental), custom orthotics which must be specially made and not available at retail stores.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Room Services means medical services eligible for reimbursement that are necessary to screen, evaluate, and stabilize an Emergency Medical Condition and are provided at a hospital Emergency Room and billed by a hospital.

Employee means a full-time Employee as defined by a Participant Employer and in accordance with state law.

Employee Coverage means Plan benefits with respect to the Employee only.

Family Unit Limit means that each of three covered members of a family unit has met the dollar amount shown in the Schedule of Benefits as Plan Year deductible for an individual. Once the Family Unit limit is met, the deductibles of all other covered members of the family unit will be considered satisfied for that Plan Year.

Fee Schedule means the maximum allowable charges for professional or hospital services adopted by OGB that may be considered as an Eligible Expense.

Generic Drug means a chemically equivalent copy of a “brand name” drug.

Group Health Plan means a plan (including a self-insured plan) offered or contributed to, by an employer (including a self-employed person) or employee organization to provide health care to employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, and/or their families.

Health Insurance Coverage means benefits consisting of medical care offered by a health insurance issuer under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract.

Health Maintenance Organization (HMO) means a legal entity which has received a certificate of authority from the Louisiana Commissioner of Insurance to operate as a health maintenance organization in Louisiana.

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 that is currently licensed as a hospital by the state in which services are rendered and is not primarily an institution for rest, the aged, the treatment of pulmonary tuberculosis, a nursing home, extended care facility, remedial training institution, or a facility primarily for the treatment of conduct and behavior disorders.

Incurred Date means the date when a particular service or supply is rendered or obtained. When a single charge is made for a series of services; each service will bear a prorated share of the charge.

Inpatient Confinement means a hospital stay that is equal to or exceeds 24 hours.

Lifetime Maximum Benefit means the maximum amount of benefits that will be paid under the Plan for all Eligible Expenses incurred by a Covered Person.

Medically Necessary means a service, treatment, procedure, equipment, drug, device, item, or supply, which, in the judgment of the Program:

1. Is appropriate and consistent with a Covered Person’s diagnosis and treatment as well as with nationally accepted medical standards; and
2. Is not primarily for personal comfort or convenience or Custodial Care.

Medicare refers to the health insurance available through Medicare laws enacted by the Congress of the United States.

Network Pharmacy means a pharmacy that participates in a network established and maintained by a prescription benefits management firm with which the Program has contracted to provide and administer outpatient prescription drug

benefits.

Occupational Therapy means the application of any activity one engages in for the purposes of evaluation, interpretation, treatment planning, and treatment of problems interfering with functional performance in persons impaired by physical illness or injury in order to significantly improve functioning.

Office of Group Benefits (OGB) means the entity created and empowered to administer the programs of benefits authorized or provided for under the provisions of Chapter 12 of Title 42 of the Louisiana Revised Statutes.

Outpatient Surgical Facility means an ambulatory surgical facility licensed by the state in which services are rendered.

Pain Rehabilitation Control and/or Therapy means a program designed to develop an individual's ability to control or tolerate chronic pain.

Participant Employer means a state entity, school board, or a state political subdivision authorized by law to participate in this Program.

Participant Provider means PPO, as defined herein.

Physical Therapy means the evaluation of physical status as related to functional abilities and treatment procedures as indicated by that evaluation, and licensed for the state where services are rendered.

Physician means the following persons, appropriately licensed to practice their respective professional skills at the time and place the service is rendered:

1. Doctors of Medicine (M.D.);
2. Doctors of Dental Surgery (D.D.S.);
3. Doctors of Dental Medicine (D.M.D.);
4. Doctors of Osteopathy (D.O.);
5. Doctors of Podiatric Medicine (D.P.M.);
6. Doctors of Chiropractic (D.C.);
7. Doctors of Optometry (O.D.);
8. Psychologists meeting the requirements of the National Register of Health Service Providers in Psychology;
9. Mental health counselors;
10. Substance abuse counselors;
11. Audiologists.

The term Physician does not include a medical doctor in the capacity of supervising interns, residents, senior residents, or fellows enrolled in a training program who does not personally provide medical treatment or perform a surgical procedure for the Covered Person.

Plan means coverage offered by the Office of Group Benefits under this contract, including PPO benefits, prescription drug benefits, mental health and substance abuse benefits, and comprehensive medical benefits. The term Plan as defined herein is used interchangeably with the term Program as defined below.

Plan Member means a Covered Person other than a Dependent.

Plan Year means the period from January 1, or the date the Covered Person first becomes covered under the Plan, through December 31. Each successive Plan Year will be the twelve month period from January 1 through December 31.

PPO means a Preferred Provider Organization. A PPO is a medical provider such as a hospital, doctor, or clinic who entered into a contractual agreement with the Program to provide medical services to Covered Persons at a reduced or discounted price.

Preventive Services or Recommended Preventive Services under the Affordable Care Act means:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. Recommendations of the United States Preventive Services Task Force are not required to be covered immediately after the release of the recommendation or guideline. Timing rules apply by law.
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Program means the Office of Group Benefits Program and/or Plan.

Provider means one or more entities which offer health care services and shall include but not be limited to hospitals, individuals, or groups of physicians, individuals or groups of psychologists, nurse midwives, ambulance service companies, and other health care entities who provide Covered Services to Covered Individuals.

Recovery, with respect to Subrogation and Reimbursement, means any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for losses allegedly caused by injury or sickness, whether or not the losses reflect medical or dental charges covered by the Program.

Rehabilitation and Rehabilitation Therapy means care concerned with the management and functional ability of patients disabled by disease, illness, accident, or injury.

Reimbursement means repayment to the Program for Benefits Payments made by the Program.

Retiree means an individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

1. Immediately received retirement benefits from an approved state or governmental agency defined benefit plan;
2. Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
 - a. Began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or
 - b. Began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
 - c. Was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
 - d. Maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan.

3. Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.
4. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2, or 3 above.

Room and Board means all hospital expenses necessary to maintain and sustain a Covered Person upon admittance to a hospital during a confinement. This can include but is not limited to facility charges for the maintenance of the Covered Person's hospital room, dietary and food services, nursing services performed by nurses employed by or under contract with the hospital, and housekeeping services.

Stop Loss Provision represents the co-insurance amount for which the Plan Member is responsible. This amount does not include any deductibles or ineligible expenses. The Plan Member's Stop Loss will be the difference between the Program's payment and the Eligible Expense.

Subrogation means the Program's right to pursue the Covered Person's claims for medical or dental charges against a liability insurer, a responsible party, or the Covered Person.

Temporary Appointment means an appointment to any position for a period of 120 consecutive calendar days or less.

Treatment includes consultations, examinations, diagnoses, and medical services rendered in the care of a Covered Person.

Utilization Management means the process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Utilization Review Organization (URO) means an entity that has established one or more utilization review programs, which evaluates the medical necessity, appropriateness and efficiency of the use of health care services, procedures, and facilities.

ARTICLE 1 **ELIGIBILITY**

I. PERSONS TO BE COVERED

Eligibility requirements apply to all participants in the Program, including the PPO plan, the HMO plan, the Medical Home HMO plan or the life insurance plan.

A. Employee Coverage

1. Employee

A full-time Employee as defined by a Participant Employer and in accordance with state law.

2. Husband and Wife, Both Employees

No one may be enrolled simultaneously as an Employee and as a Dependent under the Plan, nor may a Dependent be covered by more than one Employee. If a covered Spouse chooses to be covered separately at a later date and is eligible for coverage as an Employee, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase benefits.

3. Effective Dates of Coverage, New Employee, Transferring Employee

Coverage for each Employee who completes the applicable Enrollment Form and agrees to make the required payroll contributions to his Participant Employer is effective as follows:

- a. If employment begins on the first day of the month, coverage is effective on the first day of the following month (For example, if hired on July 1, coverage will begin on August 1);
- b. If employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15, coverage will begin on September 1);
- c. Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will be considered an overdue applicant.
- d. An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the Employee will be considered an overdue applicant.

4. Re-Enrollment, Previous Employment for Health Benefits and Life Insurance

- a. An Employee, whose employment terminated while covered and is re-employed within 12 months of the termination date, will be considered a Re-Enrollment Previous Employment applicant. A Re-Enrollment Previous Employment applicant will only be eligible for the classification of coverage (Employee, Employee and Child(ren), Employee and Spouse, Family) in force on the effective termination date.
- b. If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within 30 days of re-employment.

5. Members of Boards and Commissions

Except as otherwise provided by law, members of boards or commissions are not eligible for participation in the Plan. This provision does not apply to members of school boards, state boards, or commissions as defined by the Participant Employer as full-time Employees.

6. Legislative Assistants

Legislative Assistants are eligible to participate in the Plan if they are declared full-time Employees by the Participant Employer and have at least one year of experience or receive at least 80% of their total compensation as Legislative Assistants.

7. Pre-Existing Condition (PEC) – New Employees

- a. The terms of the following paragraph apply to all eligible Employees and their Dependents whose employment with a Participating Employer begins on or after July 1, 2001.
- b. The Program may require that such applicants complete an “Acknowledgment of Pre-existing Condition” form.
- c. Medical expenses incurred during the first 12 months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately prior to the enrollment date. This provision does not apply to pregnancy or to any covered individual under the age of nineteen (19).
- d. If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid, or other creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred without a break for 63 days or more for the duration of prior coverage against the initial 12-month period. Any coverage occurring prior to a break in coverage 63 days or more will not be credited against a pre-existing condition exclusion period.

B. Retiree Coverage

1. Eligibility

- a. Retirees of Participant Employers are eligible for Retiree coverage under this Plan.
- b. An Employee retired from a Participant Employer may not be covered as an Employee.
- c. **RETIRES ARE NOT ELIGIBLE FOR COVERAGE AS OVERDUE APPLICANTS.**

2. Effective Date of Coverage

- a. Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions. (For example, if retired July 15, coverage will begin August 1.)

C. Dependent Coverage

1. Eligibility

A Dependent of an eligible Employee or Retiree will be eligible for Dependent Coverage on the latest of the following dates:

- a. The date the Employee becomes eligible;

- b. The date the Retiree becomes eligible;
 - c. The date the covered Employee or covered Retiree acquires a Dependent.
2. Effective Dates of Coverage

a. Dependents of Employees

Coverage will be effective on the date the Employee becomes eligible for Dependent Coverage.

b. Dependents of Retirees

Coverage for Dependents of Retirees will be effective on the first day of the month following the date of retirement if the Employee and his Dependents were covered immediately prior to retirement. Coverage for Dependents of Retirees first becoming eligible for Dependent Coverage following the date of retirement will be effective on the date of marriage for new Spouses, the date of birth for newborn Children, or the Date Acquired for other classifications of Dependents. Application must be made within 30 days of the date of eligibility for coverage.

D. Pre-Existing Condition (PEC) – Overdue Application

1. The terms of the following paragraphs apply to all eligible Employees who apply for coverage after 30 days from the date the Employee became eligible for coverage and to all eligible Dependents of Employees and Retirees for whom the application for coverage was not completed within 30 days from the Date Acquired.

The effective date of coverage will be:

- a. The first day of the month following the date the Program receives all required forms prior to the 15th of the month;
 - b. The first day of the second month following the date the Program receives all required forms on or after the 15th of the month.
2. The Program may require that such applicants complete an “Acknowledgement of Pre-existing Condition” form.
3. Medical expenses incurred during the first 12 months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the enrollment date. This provision does not apply to pregnancy or to any covered individual under the age of nineteen (19).
4. If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid or other creditable coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred continuously for 63 days or more for the duration of prior coverage against the initial 12-month period. Any coverage occurring prior to a break in coverage 63 days or more will not be credited against a pre-existing condition exclusion period.

E. Special Enrollments – HIPAA

In accordance with HIPAA, certain eligible persons for whom the option to enroll for coverage was previously declined, and who would be considered overdue applicants, may enroll by written application to the Participant Employer under the following circumstances, terms, and conditions for special enrollments:

1. Loss of Other Coverage

Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined because the Employees or Dependents had other coverage which terminated due to:

- a. Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan Participant; or
- b. Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer's contributions were ceased for cause or for failure of the individual Participant to make contributions; or
- c. The Employee or Dependent having had COBRA continuation coverage under a Group Health Plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA.

2. After Acquired Dependents

Special enrollment will be permitted for Employees or Dependents for whom the option to enroll for coverage was previously declined when the Employee acquires a new Dependent by marriage, birth, adoption, or placement for adoption.

- a. A special enrollment application must be made within 30 days of either the termination date of the prior coverage or the date the new Dependent is acquired. If it is made more than 30 days after eligibility, they will be considered overdue applicants subject to a pre-existing condition limitation.
- b. The effective date of coverage shall be:
 1. For loss of other coverage or marriage, the first day of the month following the date the Program receives all required forms for enrollment;
 2. For birth of a Dependent, the date of birth;
 3. For adoption, the date of adoption or placement for adoption.
- c. Special enrollment applicants may be required to complete an "Acknowledgment of Pre-existing Condition" form.
- d. Medical expenses incurred during the first 12 months that coverage for the Special Enrollee is in force under this Plan will not be considered as covered medical expenses if they are in connection with a disease, illness, accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the enrollment date. This does not apply to pregnancy or to any covered individual under the age of nineteen (19).
- e. If the Special Enrollee was previously covered under a Group Health Plan, Medicare, Medicaid or other creditable coverage as defined in HIPAA, the duration of the prior coverage will be credited against the initial 12-month period used by the Program to exclude benefits for a pre-existing condition if the termination under the prior coverage occurred within 63 days of the date of coverage under the Plan.

F. Retirees Special Enrollment

Retirees will not be eligible for special enrollment, except under the following conditions:

1. Retirement began on or after July 1, 1997;
2. The Retiree can document that creditable coverage was in force at the time of the election not to participate or continue participation in the Plan;

3. The Retiree can demonstrate that creditable coverage was maintained continuously from the time of the election until the time of requesting special enrollment;
4. The Retiree has exhausted all COBRA and/or other continuation rights and has made a formal request to enroll within 30 days of the loss of other coverage; and
5. The Retiree has lost eligibility to maintain other coverage through no fault of his/her own and has no other creditable coverage in effect.

G. Health Maintenance Organization (HMO) Option

1. In lieu of participating in the Plan, Employees and Retirees may elect coverage under an approved HMO.
2. New Employees may elect to participate in an HMO during their initial period of eligibility. Each HMO will hold an annual enrollment period for coverage effective date of January 1. Transfer of coverage from the Plan to the HMO or vice-versa will only be allowed during this annual enrollment period.
 - a. Transfer of coverage will be allowed as a result of the Employee being transferred into or out of the HMO geographic service area, with an effective date of the first day of the month following transfer.
3. If a Covered Person has elected to transfer coverage but is hospitalized on January 1, the plan providing coverage prior to January 1 will continue to provide coverage up to the date of discharge from the hospital.

H. Medicare+Choice/Medicare Advantage Option for Retirees (Effective July 1, 1999)

Retirees who are eligible to participate in a Medicare+Choice/Medicare Advantage plan who cancel coverage with the Program upon enrollment in a Medicare+Choice/Medicare Advantage plan may re-enroll in the Program upon withdrawal from or termination of coverage in the Medicare+Choice/Medicare Advantage plan, at the earlier of the following:

1. During the month of November, for coverage effective January 1; or
2. During the next annual enrollment, for coverage effective at the beginning of the next Plan Year.

I. TRICARE for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life (TFL) option on and after October 1, 2001, who cancel coverage with the Program upon enrollment in TFL may re-enroll in the Program in the event that the TFL option is discontinued or its benefits significantly reduced.

II. CONTINUED COVERAGE

A. Leave of Absence

1. Leave of Absence without Pay, Employer Contributions to Premiums
 - a. A participating employee who is granted leave of absence without pay due to a service related injury may continue coverage and the participating employer shall continue to pay its portion of health plan premiums for up to 12 months.
 - b. A participating employee who suffers a service related injury that meets the definition of a total and permanent disability under the worker's compensation laws of Louisiana may continue coverage and the participating employer shall continue to pay its portion of the premium until the employee becomes gainfully employed or is placed on state disability retirement.

- c. A participating employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA.) may continue coverage during the time of such leave and the participating employer may continue to pay its portion of premiums.
2. Leave of Absence Without Pay; No Employer Contributions to Premiums

An employee granted leave of absence without pay for reasons other than those stated in Paragraph A may continue to participate in an OGB benefit plan for a period up to 12 months upon the employee's payment of the full premiums due.

The Program must be notified by the Employee and the Participant Employer within 30 days of the effective date of the Leave of Absence.

B. Disability

1. Employees who have been granted a waiver of premium for Basic or Supplemental Life Insurance prior to July 1, 1984, may continue health coverage for the duration of the waiver if the Employee pays the total contribution to the Participant Employer. Disability waivers were discontinued effective July 1, 1984.
2. If a Participant Employer withdraws from the Plan, health and life coverage for all Covered Persons will terminate on the effective date of withdrawal.

C. Surviving Dependents/Spouse

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.
 - a. The surviving legal Spouse of an Employee or Retiree may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage in a Group Health Plan other than Medicare;
 - b. The surviving, Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a Group Health Plan other than Medicare or until attainment of the termination age for Children, whichever occurs first;
 - c. Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees and Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits;
 - d. Coverage provided by the Civilian Health and Medical Program for the Uniform Services (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal Spouse or a Dependent Child.
2. A surviving Spouse or Dependent cannot add new Dependents to continued coverage other than a child of the deceased Employee born after the Employee's death.
3. Participant Employer/Dependent Responsibilities
 - a. It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Program within 60 days of the death of the Employee or Retiree;
 - b. The Program will notify the surviving Dependents of their right to continue coverage;
 - c. Application for continued coverage must be made in writing to the Program within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;

- d. Coverage for the surviving Spouse under this section will continue until the earliest of the following :
 - i. Failure to pay the applicable premium timely;
 - ii. Eligibility of the surviving Dependent Child under a Group Health Plan other than Medicare.
 - e. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:
 - i. Failure to pay the applicable premium timely;
 - ii. Eligibility of the surviving Dependent Child for coverage under any Group Health Plan other than Medicare; or
 - iii. The attainment of the termination age for Children.
4. The provisions of paragraphs 1 through 3 of this subsection are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. Over-Age Dependents

If a Dependent Child is incapable (and became incapable prior to attainment of age 26) of self-sustaining employment the coverage for the Dependent Child may be continued for the duration of incapacity.

- 1. Prior to the Dependent Child reaching age 26, an application for continued coverage with current medical information from the Dependent Child's attending Physician must be submitted to the Program to establish eligibility for continued coverage as set forth above.
- 2. Upon receipt of the application for continued coverage the Program may require additional medical documentation regarding the Dependent Child's mental retardation or physical incapacity as often as it may deem necessary thereafter.

E. Military Leave

Members of the National Guard or of the United States military reserves who are called to active military duty, and who are OGB participating Employees or covered Dependents will have access to continued coverage under OGB's health and life plans.

1. Health Plan Participation

When called to active military duty, participating employees and covered dependents may:

- a. Continue participation in the OGB health plan during the period of active military service, in which case the participating employer may continue to pay its portion of premiums; or
- b. Cancel participation in the OGB health plan during the period of active military service, in which case such plan participants may apply for reinstatement of OGB coverage within 30 days of:
 - i. The date of the **Employee's** reemployment with a participating employer;
 - ii. The **Dependent's** date of discharge from active military duty; or
 - iii. The date of termination of extended health coverage provide as a benefit of active military duty, such as TRICARE Reserve Select;
 - iv. Plan participants who elect this option and timely apply for reinstatement of OGB coverage will not be subject to a pre-existing condition (PEC) limitation, and the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding Rules promulgated by OGB.

2. Life Insurance

When called to active military duty, Employees with OGB life insurance coverage may:

- a. Continue participation in the OGB life insurance during the period of active military service, however, the **Accidental Death and Dismemberment** coverage will not be in effect during the period of active military duty; or
- b. Cancel participation in the OGB life insurance during the period of active military service; in which case such **Employee** may apply for reinstatement of OGB life insurance within 30 days of the date of the **Employee's** reemployment with a participating employer; **Employees** who elect this option and timely apply for reinstatement of OGB life insurance will not be required to provide evidence of insurability.

III. COBRA

A. Employees

1. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.
2. It is the responsibility of the Participant Employer to notify the Program within 30 days of the date coverage would have terminated because of any of the foregoing events and the Program will notify the Employee within 14 days of his or her right to continue coverage.
3. Application for continued coverage must be made in writing to the Program within 60 days of the date of the election notification, and premium payment must be made within 45 days of the date the Employee elects continued coverage, for coverage retroactive to the date it would have otherwise terminated.
4. Coverage under this section will continue until the earliest of the following:
 - a. Failure to pay the applicable premium timely;
 - b. 18 months from the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
 - e. The Employer ceases to provide any group health plan for its employees.
5. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered spouse and/or covered dependent children may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the above stated notification and termination provisions.

B. Surviving Dependents

1. Coverage under this Plan for covered surviving Dependents of an Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at his/her own expense.
2. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Program within 30 days of the death of the Employee or Retiree. The Program will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the date of the election notification.
3. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for the surviving Dependents under this section will continue until the earliest of the following:
 - a. Failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. Entitlement to Medicare;
 - d. Coverage under a Group Health Plan, but only after pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
 - e. The Employer ceases to provide any group health plan for its employees.

C. Divorced Spouse

1. Coverage under this Plan for an Employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the Employee or Retiree, unless the covered divorced Spouse elects to continue coverage at his or her own expense.
2. It is the responsibility of the divorced Spouse to notify the Program within 60 days from the date of divorce, and the Program will notify the divorced Spouse within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the election notification.
3. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for the divorced Spouse under this section will continue until the earliest of the following:
 - a. Failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. Entitlement to Medicare;
 - d. Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
 - e. The Employer ceases to provide any group health plan for its employees.

D. Dependent Children

1. Coverage under this plan for a covered Dependent Child of a covered Employee or Retiree will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent elects to continue coverage at his or her own expense.
2. It is the responsibility of the Dependent to notify the Program within 60 days of the date coverage would have terminated and the Program will notify the Dependent within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of receipt of the election notification.
3. Premium payment must be made within 45 days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for Children under this section will continue until the earliest of the following:
 - a. Failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. Entitlement to Medicare;
 - d. Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
 - e. The Employer ceases to provide any group health plan for its employees.

E. Dependents of COBRA Participants

1. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered spouse or a covered dependent child becomes ineligible for coverage due to:
 - a. Death of the Employee;
 - b. Divorce from the Employee; or
 - c. A Dependent Child no longer meets the definition of an eligible covered Dependent;Then, the spouse and/or dependent child may elect to continue COBRA coverage at his or her own expense. Coverage will not be continued beyond 36 months from the date coverage would have otherwise terminated.
2. It is the responsibility of the spouse and/or the dependent child to notify the Program within 60 days of the date COBRA coverage would have terminated.
3. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for the Children under this section will continue until the earliest of the following:
 - a. Failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;

- c. Entitlement to Medicare;
- d. Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. The Employer ceases to provide any group health plan for its employees.

F. Disability COBRA

1. If a Covered Employee or Covered Dependent is determined by the Social Security Administration or by the Program staff (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient “quarters” of employment) to have been totally disabled on the date the Covered Person became eligible for continued coverage or within the initial 18 months of coverage, coverage under this Plan for the Covered Person who is totally disabled may be extended at his or her own expense up to a maximum of 29 months from the date coverage would have otherwise terminated.
2. To qualify, the Covered Person must:
 - a. Submit a copy of his or her Social Security Administration’s disability determination to the Program before the initial 18-month continued coverage period expires and within 60 days after the latest of:
 - i. The date of issuance of the Social Security Administration’s disability determination; and
 - ii. The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Plan as a result of the covered employee’s termination or reduction of hours.
 - b. In the case of a person who is ineligible for Social Security disability benefits due to insufficient “quarters” of employment, submit proof of total disability to the Program before the initial 18-month continued coverage period expires. The staff and medical director of the Program will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant’s physicians, work history, and other relevant evidence presented by the applicant.
3. For purposes of eligibility for continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.
4. Monthly payments for each month of extended COBRA coverage are due on the first day of the month for that month’s COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
5. Coverage under this section will continue until the earliest of the following:
 - a. Failure to pay the applicable premium timely;
 - b. 29 months from the date coverage would have otherwise terminated;
 - c. Entitlement to Medicare;
 - d. Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied;
 - e. The Employer ceases to provide any group health plan for its employees; or

- f. 30 days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Program within 30 days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient “quarters” of an employment, 30 days after the month in which the Program determines that the Covered Person is no longer disabled.

G. Medicare COBRA

1. If an Employee becomes entitled to Medicare less than 18 months before the date the Employee’s eligibility for benefits under this Plan terminates, the period of continued coverage available for the Employee’s covered Dependents will continue until the earliest of the following:
 - a. Failure to pay the applicable premium timely;
 - b. 36 months from the date of the Employee’s Medicare entitlement;
 - c. Entitlement to Medicare;
 - d. Coverage under a Group Health Plan, but only after any pre-existing conditions exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
 - e. The Employer ceases to provide any group health plan for its employees.
2. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month’s COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

H. Miscellaneous Provisions

During the period of continuation, benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees and Retirees.

IV. CHANGE OF CLASSIFICATION

A. Adding or Deleting Dependents

The Plan Member must notify the Program when a Dependent is added to or deleted from the Plan Member's coverage that results in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. Change in Coverage

1. When there is a change in family status (e.g., marriage, birth of child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within 30 days of the date of the event.
2. When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the 15th day of the month. If the date of change occurs on or after the 15th day of the month, an additional premium will not be charged until the first day of the following month.

C. Notification of Change

It is the Employee’s responsibility to notify the Program of any change in classification of coverage that affects the Employee’s contribution amount. If failure to notify is later determined, it will be corrected on the first day of the following month.

V. CONTRIBUTIONS

The State of Louisiana may make a contribution toward the cost of the Plan, as determined on an annual basis by the Legislature.

ARTICLE 2
TERMINATION OF COVERAGE

I. ACTIVE EMPLOYEE AND RETIRED EMPLOYEE COVERAGE

- A. Subject to continuation of coverage and COBRA rules, all benefits of a Covered Person will terminate under this Plan on the earliest of the following dates:
1. The date the Program terminates;
 2. The date the group or agency employing the covered Employee terminates or withdraws from the Program;
 3. The date contribution is due if the group or agency fails to pay the required contribution for the covered Employee;
 4. The date contribution is due if the Covered Person fails to make any contribution which is required for the continuation of coverage;
 5. The last day of the month of the covered Employee's death;
 6. The last day of the month in which the covered Employee ceases to be eligible.

II. DEPENDENT COVERAGE ONLY

- A. Subject to continuation of coverage and COBRA rules, Dependent coverage will terminate under this Plan on the earliest of the following dates:
1. The last day of the month the Employee ceases to be covered;
 2. The last day of the month in which the Dependent, as defined in this Plan, ceases to be an eligible Dependent of the covered Employee;
 3. For grandchildren for whom the employee does not have legal custody or has not adopted, the date the child's parent ceases to be a covered Dependent under this Plan or the grandchild no longer meets the definition of Children
 4. Upon discontinuance of all Dependent coverage under this Plan.

ARTICLE 3

MEDICAL BENEFITS

I. MEDICAL BENEFITS

Medical Benefits apply when Eligible Expenses are incurred by a Covered Person.

A. Eligible Expenses

Eligible Expenses are the charges incurred for the following services, drugs, supplies, and devices, when performed, prescribed, or ordered by a Physician and Medically Necessary for the Treatment of a Covered Person. All charges are subject to the applicable deductibles, copayments, and/or coinsurance amounts (unless otherwise specifically provided), Fee Schedule limitations, Schedule of Benefits, exclusions, and other provisions of the Plan. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished. Eligible Expenses are:

1. Hospital Care The medical services, supplies, treatment, drugs, and devices furnished by a hospital or ambulatory surgical center. Covered charges for room and board are payable as shown in the Schedule of Benefits;
2. Covered Services of a Physician;
3. Routine Nursing Services, i.e., “floor nursing” services provided by nurses employed by the hospital are considered as part of the room and board;
4. Anesthesia and its administration when ordered by the operating Physician and administered by an appropriately licensed nurse anesthetist or Physician in conjunction with a covered surgical service;
5. Laboratory examinations and diagnostic X-rays;
6. Nuclear medicine and electroshock therapy;
7. Blood, blood derivatives, and blood processing, when not replaced;
8. Surgical and medical supplies billed for treatment received in a hospital or ambulatory surgical center, as well as the following surgical and medical supplies furnished by covered Providers:
 - a. Catheters - External and Internal
 - b. Cervical Collar
 - c. Leg Bags for Urinal Drainage
 - d. Ostomy Supplies, except supplies for nutritional and/or enteral feeding
 - e. Prosthetic Socks
 - f. Prosthetic Sheath
 - g. Sling (Arm or Wrist)
 - h. Suction Catheter for Oral Evacuation
 - i. Surgical Shoe (following foot surgery only)
 - j. Plaster Casts
 - k. Splints
 - l. Surgical Trays (for certain procedures)
9. Services of a licensed speech therapist when prescribed by a Physician and pre-approved through Outpatient Procedure Certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries, or other similar structural or neurological disease limited to 26 visits per Plan Year;
10. Intravenous injections, solutions, and related intravenous supplies;

11. Services rendered by a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) for the treatment of accidental injuries to a Covered Person's sound natural teeth, if:
 - a. Coverage was in effect with respect to the individual at the time of the accident;
 - b. Treatment commences within 90 days from the date of the accident and is completed within two years from the date of the accident;
 - c. Coverage remains continuously in effect with respect to the Covered Person during the course of the treatment;
 - d. Eligible Expenses will be limited to the cost of treatment as estimated at the time of initial treatment;
 - e. Eligible Expenses may include dental braces and orthodontic appliances, upon review and approval by the Program's Dental Consultant, and only under the following circumstances:
 - i. To return the alveolar alignment to its former state prior to a covered dental accident. The Program will allow benefits for orthopedic correction to establish reasonable occlusal function;
 - ii. A covered surgery that requires the use of braces for stabilization;
 - iii. Severe skeletal deformity (i.e., cleft palate). The Program will allow benefits for orthopedic correction to establish reasonable occlusal function.
 - f. As used herein, Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force;
12. Durable Medical Equipment - The Program will require written certification by the treating Physician to substantiate the Medical Necessity for the equipment and the length of time that it will be used. The purchase of Durable Medical Equipment will be considered an Eligible Expense only upon a showing that the rental cost would exceed the purchase price. Under no circumstances may the Eligible Expense for an item of Durable Medical Equipment exceed the purchase price of such item;
13. Initial prosthetic appliances. Subsequent prosthetic appliances are eligible only when acceptable certification is furnished to the Program by the attending Physician;
14. Professional ambulance services that are Medically Necessary, subject to the following provisions:
 - a. Licensed professional ambulance service in a vehicle licensed for highway use to or from a hospital with facilities to treat an illness or injury;
 - b. Licensed air ambulance service to a hospital with facilities to treat an illness or injury;
15. One pair of eyeglass lenses or contact lenses required as a result of bilateral cataract surgery performed while coverage was in force. Expenses incurred for the eyeglass frames will be limited to a maximum benefit of \$50;
16. Surgical pressure support hose, maximum three (3) pairs per plan year;
17. Ortho-mammary surgical brassieres, maximum three (3) per plan year;
18. Orthopedic shoes prescribed by a Physician and completely custom built, limited to one pair per Plan Year;
19. Acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;

20. Eligible Expenses associated with an organ transplant procedure including expenses for patient screening, organ procurement, transportation of the organ, transportation of the patient and/or donor, surgery for the patient and donor, and immunosuppressant drugs, if:
 - a. The transplantation must not be considered experimental or investigational by the American Medical Association;
 - b. The transplant surgery must be performed at a medical center which has an approved transplant program as determined by Medicare;
 - c. The Plan will not cover expenses for the transportation of surgeons or family members of either the patient or donor;
 - d. All benefits paid will be applied against the lifetime maximum benefit of the transplant recipient;
21. Services of a Physical Therapist and Occupational Therapist licensed in the state in which the services are rendered when, under the following conditions:
 - a. Services are prescribed by a licensed Physician and rendered in an individual setting;
 - b. Restorative potential exists;
 - c. Services meet the generally accepted standards for medical practice;
 - d. Services are reasonable and medical necessary for the treatment of a disease, illness, accident, injury, or post-operative condition;
 - e. Services are pre-approved through Case Management when rendered in the home;
 - f. Services are limited to 50 visits per plan year for combined physical and occupational therapy;
22. Cardiac Rehabilitation when:
 - a. Rendered at a medical facility under the supervision of a licensed Physician;
 - b. Rendered in connection with a myocardial infarction, angioplasty with or without stenting, or cardiac bypass surgery;
 - c. Completed within six months following the qualifying event;

Note: Charges incurred for dietary instruction, educational services, behavior modification literature, biofeedback, health club membership, exercise equipment, preventive programs, and any other items excluded by the Plan are not covered, unless provided for under (36) of this section.
23. Preventive Services or Recommended Preventive Services under the Affordable Care Act;
24. Specialized, age-appropriate preventive care, as follows:
 - a. One Pap test for cervical cancer per Plan Year;
 - b. Mammographic examinations performed according to the following schedule:
 - i. One mammogram during the five-year period a person is 35-39 years of age;
 - ii. One mammogram every two Plan Years for any person who is 40-49 years of age;
 - iii. One mammogram every 12 months for any person who is 50 years of age or older;
 - c. Testing for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing, once every 12 months for men over the age of 50 years;

25. Outpatient surgical facility fees as specified in the maximum payment schedule;
26. Midwifery services performed by a certified midwife or a certified nurse midwife;
27. Services rendered by the following:
 - a. Perfusionists and Registered Nurse Assistants assisting in the operating room, when billed by the supervising Physician;
 - b. Physician's Assistants and Registered Nurse Practitioners, provided that benefits will not exceed eighty percent (80%) of the amount payable for the same service rendered by a Physician;
28. Splint therapy for the treatment of Temporomandibular Joint dysfunction (TMJ), limited to a lifetime benefit of \$600 for a splint and initial panorex x-ray only. Surgical treatment for TMJ will only be eligible following a demonstrated failure of splint therapy and upon approval by the Program;
29. Oxygen and oxygen equipment;
30. Outpatient self-management training and education, including medical nutrition therapy, for the treatment of diabetes, when these services are provided by a licensed health care professional with demonstrated expertise in diabetes care and treatment who has completed an educational program required by the appropriate licensing board in compliance with the National Standards for Diabetes Self-Management Education program as developed by the American Diabetes Association, and only as follows:
 - a. A one-time evaluation and training program for diabetes self management, conducted by the health care professional in compliance with National Standards for Diabetes Self Management Education Program as developed by the American Diabetes Association, upon certification by the health care professional that the Covered Person has successfully completed the program, benefits limited to \$500;
 - b. Additional diabetes self-management training required because of a significant change in the patient's symptoms or conditions, limited to benefits of \$100 per year and \$2,000 per lifetime;
 - c. Services must be rendered at a facility with a diabetes educational program recognized by the American Diabetes Association.
31. Testing of sleep disorders only when the tests are performed at either:
 - a. A facility accredited by The American Academy of Sleep Medicine or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
 - b. A sleep study facility located within a health care facility accredited by JCAHO. No benefits are payable for surgical treatment of sleep disorders (including LAUP) except following demonstrated failure of non-surgical treatment and upon approval by the Program.
32. Mental health and/or substance abuse services only when obtained through the Program's managed care contractor as shown in the Schedule of Benefits. These services must be identified by a DSM IV diagnosis code.
33. Hearing aids for use by a covered Dependent Child under the age of 18, subject to the following limitations:
 - a. The hearing aids must be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a licensed Doctor of Medicine (M.D.) and an audiological evaluation medically appropriate to the age of the child; and
 - b. The maximum amount payable is \$1400 per hearing aid for each hearing-impaired ear every 36 months.

34. Treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol related patient care if all of the following criteria are met:
 - a. Treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;
 - b. Treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer;
 - c. Treatment is being provided in accordance with a clinical trial approved by one of the following entities;
 - i. One of the United States National Institutes of Health;
 - ii. A cooperative group funded by one of the United States National Institutes of Health;
 - iii. The FDA in the form of an investigational new drug application;
 - iv. The United States Department of Veterans Affairs;
 - v. The United States Department of Defense;
 - vi. A federally funded general clinical research center;
 - vii. The Coalition of National Cancer Cooperative Groups.
 - d. The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks;
 - e. The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
 - f. There is no clearly superior, non-investigational approach;
 - g. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and
 - h. The patient has signed an institutional review board approved consent form;
35. Routine colorectal screening provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations; including;
 - a. Fecal occult blood test
 - b. Flexible sigmoidoscopy, or
 - c. Colonoscopy
36. Treatment of ASD, which includes, but is not limited to the Medically Necessary assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. For individuals who have not yet reached their seventeenth (17th) birthday, Treatment of ASD includes Applied Behavior Analysis, when Medically Necessary. Applied Behavior Analysis is not covered for individuals age seventeen (17) and older. Benefits for Treatment of ASD are subject to applicable Copayments, Deductibles, and/or Coinsurance amounts.

II. FEE SCHEDULE

- A. The Fee Schedule establishes the maximum allowable charges for Eligible Expenses. The Fee Schedule applies to both contracted (PPO) health care providers, who have entered into agreements with OGB regarding reimbursement under this plan, and to non-contracted (non-PPO) health care providers who have not entered into such agreements.
- B. Plan Members may be subject to greater financial liability for services provided by non-contracted Providers.

III. AUTOMATED CLAIMS ADJUSTING

OGB utilizes commercially licensed software program that applies all claims against its medical logic program to identify improperly billed charges and charges for which this Plan provides no benefits. Any claim with diagnosis or procedure codes deemed inadequate or inappropriate will be automatically reduced or denied. Providers accepting assignment of benefits cannot bill the Plan Member for the differential on the denial amount, in whole or in part.

IV. UTILIZATION REVIEW — PRE-ADMISSION CERTIFICATION AND CONTINUED STAY REVIEW

- A. Pre-Admission Certification (PAC) and Continued Stay Review (CSR) establish the Medical Necessity and duration of inpatient hospital confinement.
 - 1. It is the Plan Member's responsibility to obtain PAC for non-PPO facilities.
 - 2. It is the Provider's responsibility to obtain PAC for PPO facilities. If the Provider fails to do this, the Plan Member cannot be billed for any amount not covered by this Plan.
- B. For a routine vaginal delivery, PAC is not required for a stay of two days or less. If the mother's stay exceeds or is expected to exceed two days, PAC is required within 24 hours after delivery or on the date on which any complications arose, whichever is applicable. If the baby's stay exceeds the mother's stay, PAC is required within 72 hours of the mother's discharge, and a separate pre-certification number must be obtained for the baby. In the case of a Caesarean Section, PAC is required if the mother's stay exceeds or is expected to exceed four days.
- C. No benefits will be paid under the Plan:
 - 1. Unless PAC is requested at least 72 hours prior to the planned date of admission;
 - 2. Unless PAC is requested within two business days following admission in the case of an emergency;
 - 3. For hospital charges incurred during any confinement for which PAC was requested, but which was not certified as Medically Necessary by the Program's utilization review contractor;
 - 4. For hospital charges incurred during any confinement for any days in excess of the number of days certified through PAC or CSR.
- D. Benefits otherwise payable for services at a non-PPO facility will be reduced by 25% on any confinement for which PAC was not obtained.

V. OUTPATIENT PROCEDURE CERTIFICATION (OPC)

- A. **The purpose of OPC is for the Plan to certify that particular outpatient procedures and therapies are Medically Necessary. If OPC is not obtained when required, no benefits are payable under this Plan.**

1. It is the Plan Member's responsibility to obtain OPC for services performed by a non-PPO Provider.
2. On services performed by a PPO Provider, it is the Provider's responsibility to obtain OPC.

B. OPC is required on the following procedures:

1. Speech Therapy, subject to the limitations set forth in Article 3(A)(9);
2. Hyperbaric Oxygen Therapy (HBOT).

C. No benefits will be paid for the facility fee in connection with outpatient procedures or the facility and professional fee in connection with speech therapy:

1. Unless OPC is requested at least 72 hours prior to the planned date of procedure or therapy;
2. For charges incurred on any listed procedure for which OPC was requested but not certified as Medically Necessary by the Program's utilization review contractor.
3. Services subject to a limit of 26 visits (See Article III, Section I (9))

VI. CASE MANAGEMENT

- A. Case Management (CM) is the managed care program available in cases of illness or injury where critical care is required and/or treatment of extended duration is anticipated.
- B. Case Management may provide coverage for services and that are not normally covered. To be eligible, the illness or injury must be a covered condition under the Plan, and Case Management must be approved prior to the rendering of services and/or treatment.
- C. Charges for services and/or treatment approved by the Case Management Program are subject to the deductible, co-insurance, Fee Schedule, and maximum benefit limitations.
- D. The following criteria must be met to be considered for Case Management:
 1. The Program must be the primary carrier at the time Case Management is requested. Any Case Management plan will be contingent upon the Program remaining the primary carrier;
 2. The patient must not be confined in any type of nursing home setting at the time Case Management is requested;
 3. There must be a projected savings to the Program through Case Management or a projection that Case Management expenses will not exceed normal Plan benefits; and
 - a. The proposed treatment plan will enhance the patient's quality of life;
 - b. Benefits will be utilized at a slower rate through the alternative treatment plan.
- E. Mental health and substance abuse treatments/conditions are not eligible for Case Management.
- F. Benefits are considered payable only upon the recommendation of the Program's contractor, with the approval of the attending Physician, patient or his representative, and the Program or its representative. Approval is contingent upon the professional opinion of the Program's medical director, consultant, or his designee as to the appropriateness of the recommended alternative care.
- G. If a condition is likely to be lengthy or if care could be provided in a less costly setting, the Program's contractor may recommend an alternative plan of care to the Physician and patient.

VII. DENTAL SURGICAL BENEFITS

- A. When excision of one or more impacted teeth is performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) while coverage is in force, the Program will pay, without deductible, the Eligible Expense actually incurred for the surgical procedure.
- B. If a Covered Person requires dental treatment in a hospital setting that is otherwise an Eligible Expense, the Plan will provide benefits for anesthesia rendered in the hospital and associated hospital charges.
 - 1. Prior authorization for hospitalization for dental treatment is required in the same manner as prior authorization is required for other covered medical services.
- C. Eligible Expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, pathology services, and facility charges are subject to a deductible, co-insurance, and the maximum benefit provisions of the Plan.
- D. The provisions of this section shall not apply to Treatment rendered for Temporomandibular Joint (TMJ) diseases or disorders.

VIII. MEDICARE AND O.G.B.

- A. When an individual is covered by this plan and by Medicare, Medicare laws and regulations govern the order of benefit, that is, whether Medicare is the primary or secondary payer.
- B. Except as provided in Subsection C (below), when an individual is covered by this plan and by Medicare, and:
 - 1. This plan is the primary payer, benefits will be paid without regard to Medicare coverage;
 - 2. Medicare is the primary payer, Eligible Expenses under this plan will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. All provisions of this plan, including all provisions related to deductibles, co-insurance, limitations, exceptions, and exclusions will be applied.
- C. The following applies to Retirees and to covered spouses of Retirees who attain or have attained the age of 65 on or after July 1, 2005:
 - 1. Upon attainment of age 65, a Retiree and/or the Retiree's spouse may be eligible for Medicare if the Retiree or Retiree's spouse has sufficient earnings credits.
 - 2. A Retiree or spouse of a Retiree who attains or has attained age 65 when either has sufficient earnings credits to be eligible for Medicare, MUST ENROLL in Medicare Part A AND Medicare Part B in order to receive benefits under this plan except as specifically provided in paragraph 3, below.
 - 3. If such Retiree or spouse of a Retiree is not enrolled in Medicare Part A and Medicare Part B, NO BENEFITS will be paid or payable under this plan except benefits payable as secondary to the Part of Medicare in which the individual is enrolled.
 - 4. A Retiree and spouse of a Retiree who do not have sufficient earnings credits to be eligible for Medicare must provide written verification from the Social Security Administration or its successor.
- D. Retiree 100-Medicare COB – Upon enrollment and payment of the additional monthly premium, a Plan Member and Dependents who are covered under Medicare Parts A and B (both) may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare, within 30 days of retirement if already eligible for Medicare, or at annual enrollment.

IX. EXCEPTIONS AND EXCLUSIONS

- A. No benefits are provided under this Plan for the following:
 - 1. Injury compensable under any worker's compensation program, regardless of whether the patient has filed a claim for benefits. This applies to compensation provided on an expense-incurred basis or blanket settlements for past and future losses;
 - 2. Maintenance therapy consisting of convalescent, skilled nursing, sanitarium, custodial care, assisted living facilities, or rest cures designed to assist in daily living activities, maintain present physical and/or mental condition, or provide a structured or safe environment;
 - 3. Expenses for elective, non-therapeutic voluntary abortions (abortions performed for reasons other than to save the life of the mother);
 - 4. Injuries sustained by a Covered Person while in an aggressor role;
 - 5. Expenses incurred as a result of a Covered Person's commission or attempted commission of an illegal act;
 - 6. Services, supplies, or treatment for cosmetic purposes, including cosmetic surgery and any cosmetic

- complications of cosmetic surgery, unless necessary for the immediate repair of a deformity caused by a disease and/or injury that occurs while coverage is in force. No payment will be made for expenses incurred in connection with the treatment of any body part not affected by the disease and/or injury;
7. Shoes and related items, such as wedges, cookies, and arch supports;
 8. Dental and orthodontic services, appliances, supplies, and devices, including, but not limited to the following:
 - a. Dental braces and orthodontic appliances, except as specifically provided in Article 3, Section (I) (11) (e), herein;
 - b. Treatment of periodontal disease;
 - c. Dentures, dental implants, and any surgery for their use, except if needed as the result of an accident that meets the Program's requirements;
 - d. Treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in Article 3, section (I) (28), herein;
 - e. Expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial surgeries which are shown to the satisfaction of the Program to be Medically Necessary, non-dental, non-cosmetic procedures;
 9. Medical services, supplies, treatments, and prescription drugs provided without charge to the Covered Person or for which the Covered Person is not legally obligated to pay;
 10. Maternity expenses incurred by any person other than the Employee or the Employee's legal Spouse;
 11. Personal convenience items including, but not limited to, admit kits, bedside kits, telephone, television, guest meals, and beds, and charges for luxury accommodations in any hospital or allied health facility provided primarily for the patient's convenience which are not deemed Medically Necessary by the Program;
 12. Charges for services, supplies, treatment, drugs, and devices which are in excess of the maximum allowable under the Medical Fee Schedule, Outpatient Surgical Facility Fee Schedule, or any other limitations of the Plan;
 13. Services, supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed Medically Necessary by the Program;
 14. Services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, pain rehabilitation control and/or therapy, and dietary or educational instruction for all diseases and/or illnesses, except diabetes;
 15. Services and supplies for the treatment of and/or related to gender dysphoria or reverse sterilization;
 16. Artificial organ implants, penile implants, transplantation of non-human organs, and any surgery and other treatment, services, or supplies, related to such procedures, or to complications related to such procedures;
 17. Expenses subsequent to the initial diagnosis for infertility and complications, including but not limited to, services, drugs, procedures, or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, donor eggs, and reversal of sterilization procedures;

18. Non-medical supplies such as air conditioners and/or filters, dehumidifiers, air purifiers, wigs or toupees, heating pads, cold devices, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy tests, lift chairs, devices or kits to stimulate the penis, exercise equipment, any other items not normally considered medical supplies, and any items the Program determines are not medical supplies;
19. Administrative fees, interest, penalties, or sales tax;
20. Marriage counseling, family relations counseling, divorce counseling, parental counseling, job counseling, and career counseling;
21. Charges for Physician services rendered to a Covered Person over the telephone or in a non-face-to-face setting;
22. Radial keratotomy, laser surgery, and any other procedures, services, or supplies for the correction of refractive errors of the eyes;
23. Services, supplies, surgeries, and treatments for excess body fat, resection of excess skin and/or fat following weight loss or pregnancy, and/or obesity, and morbid obesity.
24. Hearing aids and any examination to determine the fitting or necessity of hearing aids, except as specifically provided for in Article 3, Section I (33);
25. Hair plugs and/or transplants;
26. Routine physical examinations and/or immunizations not provided for under Eligible Expenses;
27. Routine eye examinations, glasses, and contact lenses, except as specifically provided for as an Eligible Expense in Article 3, Section I (15);
28. Diagnostic or treatment measures that are not recognized as generally accepted medical practice;
29. Medical supplies not listed under Eligible Expenses;
30. Treatment or services for mental health and substance abuse provided outside the treatment plan developed by the Program's managed care contractor or by therapists with whom or at facilities with which the Program's managed care contractor does not have a contract;
31. Molecular laboratory procedures related to Genetic Testing except when determined to be Medically Necessary during a covered pregnancy, or for histocompatibility/blood typing, neoplasia, hereditary disorders, or other condition approved in advance by OGB;
32. Services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.);
33. Services rendered by a Physician or other health care Provider related to the patient by blood, adoption, or marriage;
34. Expenses for services rendered by a Physician or other health care Provider who is not licensed in the state where such services are rendered or in any facility not holding a valid license in the state and for the services rendered;
35. Facility fees for services rendered in a Physician's office or in any facility not approved by the federal Health Care Finance Administration for Medicare reimbursement;
36. Glucometers;

37. Augmentative communication devices;
38. Charges to obtain medical records or any other information needed and/or required to adjudicate a claim;
39. Charges greater than the global allowance for any laboratory, pathology, or radiological procedure.
40. Speech therapy or the services of a speech therapist except as specifically provided in Article 3, Section I (9).

X. COORDINATION OF BENEFITS

- A. Coordination of benefits is the order of payment when two or more plans are involved. When a patient is covered by another plan, the plans will coordinate benefits.
- B. A benefit plan is this Plan or any one of the following:
 1. Group or employer sponsored plan;
 2. Group practice and other group prepayment plan;
 3. Other plans required or provided by law. This does not include Medicaid or any benefit plan that does not allow coordination.
- C. Primary Plan and Secondary Plan
 1. All benefits provided are subject to coordination of benefits.
 2. Benefit plan payment order:
 - a. If an individual is covered by more than one plan, the order of benefit payment will follow guidelines established by the National Association of Insurance Commissioners.
 - b. The plan that pays first will pay as if no other plan is involved. The secondary and subsequent plans may pay the balance due up to 100% of the total Eligible Expenses. No plan will pay benefits greater than it would have paid in the absence of coordination of benefits.

XI. PREFERRED PROVIDER PROGRAM

The Program may implement Preferred Provider Organization (PPO) arrangements or other agreements to discount payable fees. The Program reserves the right to negotiate the amount of discounts, incentives offered to Plan Members, and all other provisions which are a part of any discount fee arrangement. To be eligible, the Program must be the primary carrier at the time services are rendered.

The only exception is for a Covered Person with only Medicare Part A who did not also have Part B. The Part B charges would be eligible for PPO Benefits.

- A. If a Covered Person obtains medical services or hospital services from an eligible Provider who has agreed to provide the services at a mutually agreed upon discount from the maximum medical Fee Schedule or at a per diem or discounted rate from a hospital, the Program will pay, following satisfaction of all applicable deductibles, 90% of the first \$10,000 of eligible expenses and 100% of Eligible Expenses (except prescription drugs) in excess of \$10,000 for the remainder of the Plan Year, subject to the maximum amount as specified in the Schedule of Benefits.
- B. Point of Service PPO Regions (Areas)
 1. The following regions are used to determine whether there is a PPO provider in the same area as the point of service:

- Region 1** - Zip Codes 70000 through 70199
- Region 2** - Zip Codes 70300 through 70399
- Region 3** - Zip Codes 70400 through 70499
- Region 4** - Zip Codes 70500 through 70599
- Region 5** - Zip Codes 70600 through 70699
- Region 6** - Zip Codes 70700 through 70899
- Region 7** - Zip Codes 71300 through 71499
- Region 8** - Zip Codes 71000 through 71199
- Region 9** - Zip Codes 71200 through 71299

2. If a Plan Member receives services from a PPO Provider, services are reimbursed at 90% of the Eligible Expenses, and payments made to the PPO Provider. There is contractual assignment to every PPO Provider.

If a non-PPO Provider is used by a Plan Member who resides in Louisiana, the Plan Member is reimbursed 70% of the Eligible Expenses. If a non-PPO Provider is used by a Plan Member who resides outside Louisiana, the Plan Member is reimbursed 90% of the Eligible Expenses. Eligible Expenses of non-PPO Providers are based upon the OGB's Fee Schedule.

Note: Both PPO and non-PPO services are subject to the applicable deductibles, limitations, and exclusions.

XII. PRESCRIPTION DRUG BENEFITS

- A. This Plan allows benefits for drugs and medicines approved by the U.S. Food and Drug Administration or its Successor that require a prescription and are dispensed by a licensed pharmacist or pharmaceutical company.
1. These include and shall not be limited to:
 - a. Insulin;
 - b. Retin-A dispensed for Covered Persons under the age of 27;
 - a. Vitamin B12 injections;
 - b. Prescription Potassium Chloride; and
 - e. Over-the-counter diabetic supplies including, but not limited to, strips, lancets, and swabs.
 2. In addition, this Plan allows benefits limited to \$200 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to coinsurance and co-payments relating to prescription drug benefits. In connection with this benefit, the following words shall have the following meanings:
 - a. "Inherited metabolic disease" shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:
 - i. Phenylketonuria (PKU)
 - ii. Maple Syrup Urine Disease (MSUD)
 - iii. Methylmalonic Acidemia (MMA)
 - iv. Isovaleric Adicemia (IVA)
 - v. Propionic Acidemia
 - vi. Glutaric Acidemia
 - vii. Urea Cycle Defects
 - viii. Tyrosinemia
 - b. "Low protein food products" mean food products that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include natural foods that are naturally low in protein.
- B. The following drugs, medicines, and related services and supplies are not covered:
1. Appetite suppressant drugs;
 2. Dietary supplements;
 3. Topical forms of Minoxidil;
 4. Retin-A dispensed for a Covered Person over age 26;
 5. Amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy;
 6. Nutritional or parenteral therapy
 7. Vitamins and minerals;
 8. Drugs available over the counter, except proton pump inhibitors, when prescribed by a physician;
 9. Serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting;
 10. Drugs prescribed for treatment of impotence, except following the surgical removal of the prostate gland;
 12. Glucometers.
- C. Outpatient prescription drug benefits are adjudicated by a third-party prescription benefits manager with whom the Program has contracted. In addition to all provisions, exclusions, and limitations relative to prescription drugs set forth elsewhere in this Plan, the following apply to expenses incurred for outpatient prescription drugs:
1. In Network (Participating Pharmacy) Benefits

- a. **Regular Benefits.** Upon presentation of the OGB Health Benefits Identification Card at a network pharmacy, the plan member will be responsible for payment of 50 percent of the cost of the drug, up to \$50 per prescription dispensed. The plan will pay the balance of the eligible expense for prescription drugs dispensed at a network pharmacy. There is a \$1,200 per person per plan year out-of-pocket threshold for eligible prescription drug expenses. Once this threshold is reached, that is, the plan member has paid \$1,200 of co-insurance/co-payments for eligible prescription drug expenses, the plan member will be responsible for a \$15 co-pay for brand name drugs, with no co-pay for generic drugs. The plan will pay the balance of the eligible expense for prescription drugs dispensed at a network pharmacy.
 - b. **Dispense as Written (DAW) Reduced Benefits.** The foregoing notwithstanding, when a generic is available but a brand drug is dispensed, the member will be responsible for payment of the full amount of excess cost (the difference between the brand and generic costs) in addition to the 50 percent of the cost the drug, up to \$50 per prescription dispensed.
2. In the event the plan member does not present the OGB Identification Card to the network pharmacy at the time of purchase, the plan member will be responsible for full payment for the drug and must then file a claim with the prescription benefits manager for reimbursement, which will be limited to the rates established for non-network pharmacies.
 3. If the plan member obtains a prescription drug from a non-network pharmacy in state, reimbursement will be limited to 50 percent of the amount that would have been paid if the drug had been dispensed at a network pharmacy. If the plan member obtains a prescription drug from a non-network pharmacy out of state, benefits will be limited to 80 percent of the amount that would have been paid if the drug had been dispensed at a network pharmacy.
 4. Regardless of where the prescription drug is obtained, eligible expenses for brand name drugs will be limited to:
 - a. The prescription benefits manager's maximum allowable charge for the generic, when available; or
 - b. The prescription benefits manager's maximum allowable charge for the brand drug dispensed, when a generic is not available.
 - c. There is no per prescription maximum on the plan member's responsibility for payment of costs in excess of the eligible expense. Plan member payments for such excess costs are not applied toward satisfaction of the annual out-of-pocket threshold (above).
 5. Prescription drug dispensing and refills will be limited in accordance with protocols established by the prescription benefits manager, including the following limitations.
 - a. Up to a 30-day supply of drugs may be dispensed upon initial presentation of a prescription or for refills dispensed more than 120 days after the most recent fill.
 - b. For refills dispensed within 120 days of the most recent fill, up to a 90-day supply of drugs may be dispensed at one time, provided that co-payments shall be due and payable as follows.
 - i. For a supply of 1-30 days the plan member will be responsible for payment of 50 percent of the eligible expense for the drug, up to a maximum of \$50 per prescription dispensed, and 100 percent of excess cost.
 - ii. For a supply of 31-60 days the plan member will be responsible for payment of 50 percent of the eligible expense for the drug, up to a maximum of \$100 per prescription dispensed, and 100 percent of excess cost.

- iii. For a supply of 61-90 days the plan member will be responsible for payment of 50 percent of the eligible expense for the drug, up to a maximum of \$150 per prescription dispensed, and 100 percent of excess cost.
6. Brand Drug means the trademark name of a drug approved by the U. S. Food and Drug Administration.
 7. Generic Drug means a chemically equivalent copy of a brand drug.

ARTICLE 4 **UNIFORM PROVISIONS**

I. STATEMENT OF CONTRACTUAL AGREEMENT

This Plan, as amended, including the Schedule of Benefits, together with the Application for Coverage and any related documents executed by or on behalf of the covered Employee, constitute the entire agreement between the parties.

II. PROPERLY SUBMITTED CLAIM

A. For Plan reimbursement, A CLAIM MUST INCLUDE:

1. Employee's name;
2. Name of patient;
3. Name, service address, and telephone number of the Provider;
4. Diagnosis;
5. Type of services rendered, with diagnosis and/or procedure codes that are valid and current for the date of service;
6. Date and place of service;
7. Charges;
8. Employee's member number;
9. Provider Tax Identification number; and
10. Medicare explanation of benefits, if applicable.

B. The Program may require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish information within 90 days of the request will constitute a reason for the denial of benefits.

III. WHEN CLAIMS MUST BE FILED

A. A claim for benefits must be received by the Program within one year from the date on which the medical expenses were incurred.

B. The receipt date for electronically filed claims is the date on which the Program receives the claim, not the date on which the claim is submitted to a clearinghouse or to the Provider's practice management system.

C. Requests for review of payment or corrected bills must be submitted within 18 months of receipt date of the original claim. Any requests received after that time period will not be considered.

IV. RIGHT TO RECEIVE AND RELEASE INFORMATION

- A. Without notice or consent the Program may release to or obtain from any company, organization, or person, any information regarding any person which the Program deems necessary to carry out the provisions of this Plan, or to determine how, or if, they apply. Any claimant under the Plan must furnish the Program with any information necessary to implement this provision. OGB retains information for the minimum period of time required by law. After such time, information may no longer be available.

V. LEGAL LIMITATIONS

A Plan Member must exhaust the Administrative Claims Review procedures before filing a suit for benefits. No action shall be brought to recover benefits under this Plan more than one year after the time a claim filing is required to be filed or more than 30 days after mailing of the notice of decision of the Claims Committee, whichever is later.

Information provided by the Program or any of its employees or agents to Plan Members in any medium other than a written document does not override the terms and provisions of the Plan. In the event of any conflict between the written provisions of this Plan and any verbal information provided, the written provisions of this Plan shall supercede and control.

VI. BENEFIT PAYMENTS TO OTHER GROUP HEALTH PLANS

When payments which should have been made by this Plan have been made by another group health plan, the Program may reimburse the other plan the amount necessary to satisfy the terms of this Plan.

VII. RECOVERY OF OVERPAYMENTS

If an overpayment occurs, the Program retains the right to recover the overpayment. The Covered Person, institution, or Provider receiving the overpayment must return the overpayment. At the Plan's discretion, the overpayment may be deducted from future claims.

Should legal action be required as a result of fraudulent statements or deliberate omissions on the application, the defendant will be responsible for attorney fees of 25% of the overpayment or \$1,000, whichever is greater. The defendant will also be responsible for court costs and legal interest from the date of judicial demand until paid.

VIII. SUBROGATION AND REIMBURSEMENT

- A. Upon payment of any eligible benefits covered under this Plan, the Office of Group Benefits shall succeed and be subrogated to all rights of recovery of the covered Employee, his Dependents or other Covered Persons, or their heirs or assigns, for whose benefit payment is made, and they shall execute and deliver instruments and papers and do whatever is necessary to secure such rights, and shall do nothing after loss to prejudice such rights.
- B. The Office of Group Benefits shall be entitled, to the extent of any payment made to a covered Employee, his Dependents or other Covered Persons, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a covered Employee, his Dependents or other Covered Persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made. To this end, covered Employees, their Dependents, or other Covered Persons agree to immediately notify the Office of Group Benefits of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident or injury.

- C. These subrogation and reimbursement rights **also** apply when a Covered Person recovers under, **but not limited to**, an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any **general** liability plan.

IX. EMPLOYER RESPONSIBILITY

- A. It is the responsibility of the Participant Employer to submit enrollment and change forms and all other necessary documentation to the Program on behalf of its Employees. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Program, be considered agents of the Program, and no representation made by any such person at any time will change the provisions of this Plan.
- B. A Participant Employer shall immediately inform the Program when a Retiree with OGB coverage returns to full-time employment. The Employee shall be placed in the Re-employed Retiree category for premium calculation. The Re-employed Retiree premium classification applies to Retirees with and without Medicare. The premium rates applicable to the Re-employed Retiree premium classification shall be identical to the premium rates applicable to the classification for Retirees without Medicare.
- C. A Participant Employer who receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a covered Employee. If not timely forwarded, OGB will assume responsibility only for Covered Plan benefits due to Medicare for a covered Employee. The Participant Employer will be responsible for interest, fines, and penalties due.

X. PROGRAM RESPONSIBILITY

The OGB will administer the Plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. The OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a Covered Person's rights.

XI. REINSTATEMENT TO POSITION FOLLOWING CIVIL SERVICE APPEAL

- A. Indemnity Plan Participants

When coverage of a terminated Employee, who was a participant in the health indemnity plan, is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the health indemnity plan retroactive to the date coverage terminated. The Employee and Participant Employer are responsible for the payment of all premiums for the period of time from the date of termination to the date of the final order reinstating the Employee to his position. The Program is responsible for the payment of all eligible benefits for charges incurred during this period. All claims for expenses incurred during this period must be filed with the Program within 60 days following the date of the final order of reinstatement.

- B. Health Maintenance Organization (HMO) Participants

When coverage of a terminated Employee, who was a participant in an HMO, is reinstated by reason of a civil service appeal, coverage will be reinstated in the HMO in which the Employee was participating effective on the date of the final order of reinstatement. There will be no retroactive reinstatement of coverage and no premiums will be owed for the period during which coverage with the HMO was not effective.

XII. AMENDMENTS TO OR TERMINATION OF THE PLAN AND/OR CONTRACT

OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Employee, whether active or retired.

ARTICLE 5 **CLAIMS REVIEW AND APPEAL**

I. ADMINISTRATIVE REVIEW

This section establishes and explains the procedures for review of benefit and eligibility decisions by the OGB.

A. Administrative Claims Review

A Covered Person may request from the Program a review of any claim for benefits or eligibility. The written request must include:

- a. the name of the covered person;
- b. member number;
- c. the name of the patient;
- d. the name of the provider;
- e. dates of service; and
- f. clearly state the reasons for the appeal.

The request for review must be directed to Attention: Administrative Claims Review within 90 days after the date of the notification of denial of benefits, denial of eligibility, or denial after review by the utilization review organization or prescription benefits manager.

B. Review and Appeal Prerequisite to Legal Action

The Covered Person must exhaust the Administrative Claims Review procedure before filing a suit for benefits. Unless a request for review is made, the initial determination becomes final, and no legal action may be brought to attempt to establish eligibility or recover benefits allegedly payable under the Program.

C. Administrative Claims Committee

The CEO will appoint an Administrative Claims Committee (the Committee) to consider all requests for review and to ascertain whether the initial determination was made in accordance with the Plan.

D. Administrative Claims Review Procedure and Decisions

1. Review by the Committee shall be based upon a documentary record which includes:
 - a. All information in the possession of the Program relevant to the issue presented for review;
 - b. All information submitted by the Covered Person in connection with the request for review; and
 - c. Any and all other information obtained by the Committee in the course of its review.
2. After review, the Committee will render its decision based on the Plan and the information included in the record. The decision will contain a statement of reasons for the decision.

II. APPEALS FROM MEDICAL NECESSITY DETERMINATIONS

The following provisions govern appeals from adverse determinations of Medical Necessity by OGB's Utilization Review Organization (URO).

A. **First level appeal** may be requested by the Covered Person or the Provider acting on behalf of the Covered Person within 60 days following the date of an adverse initial determination of Medical Necessity.

1. The first level appeal will be reviewed within the URO by a health care Provider with appropriate expertise.

2. The URO will provide the Covered Person with written notice of its decision.
- B. **Second level review** may be requested by the Covered Person within 30 days following the date of the notice of an adverse decision on a first level appeal.
1. The second level will be reviewed by a URO panel of health care Providers with appropriate expertise and evaluated by a clinical peer group or peers in the same/similar specialty as would typically manage the case.
 - a. The review panel will schedule and hold a review meeting. Written notice of the time and place of the review meeting will be provided to the Covered Person at least 15 working days in advance.
 - b. The Covered Person may:
 - i. Attend the second level review meeting;
 - ii. Present his/her case to the review panel;
 - iii. Submit supporting material and provide testimony in person, in writing, or by affidavit both before and at the review meeting; and
 - iv. Ask questions of any representative of the URO.
 - c. If a face-to-face meeting is not practical, the Covered Person and Provider may communicate with the review panel by conference call or other appropriate technology.
 2. The URO will provide the Covered Person with written notice of its decision within 30 days of the request for second level review.
- C. **External review** may be requested to URO by the Covered Person, with the concurrence of the treating health care Provider within 60 days after receipt of notice of a second level appeal adverse determination.
1. The URO will provide documents and any information used in making the second level appeal adverse determination to its designated independent review organization.
 2. The independent review organization will review all information and documents received and any other information submitted in writing by the Covered Person or the Covered Person's health care Provider.
 3. The independent review organization will provide notice of its recommendation to the URO, the Covered Person, and the Covered Person's health care Provider within 30 days of the request for external review.
 4. An external review decision regarding the Medical Necessity determination will be binding on the URO, the OGB, and the Covered Person.
- D. Expedited Appeals from Medical Necessity Determinations
1. An expedited appeal may be initiated by the Covered Person, with the consent of the treating health care Provider acting on behalf of the Covered Person, with regard to:
 - a. An adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
 - b. A request concerning admission, availability of care, continued stay, or health care services rendered to a Covered Person who has received emergency services but has not been discharged from a facility.
 2. The URO will make a decision and notify the Covered Person or his/her Provider as expeditiously as the Covered Person's medical condition requires, but no more than 72 hours after the appeal is commenced.
 3. The URO will provide written confirmation of its decision if the initial notification is not in writing.

4. When the expedited appeal does not resolve a difference of opinion between the URO and the Covered Person or his/her Provider the Provider may request a second level review of the adverse determination.

E. Expedited External Review of Medical Necessity Determinations

1. When the Covered Person receives an adverse determination involving an emergency medical condition while being treated in the emergency room, during hospital observation, or as a hospital inpatient, the Covered Person's health care Provider may request an expedited external review.
2. The URO will transmit all documents and information used in making the adverse determination to the independent review organization by telephone, telefacsimile, or other available expeditious method.
3. Within 72 hours after receiving appropriate medical information for an expedited external review, the independent review organization will notify the Covered Person, the URO, and the Covered Person's health care Provider of its decision to uphold or reverse the adverse determination.
4. An external review decision regarding the Medical Necessity determination will be binding on the URO, the OGB, and the Covered Person.

GENERAL NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under certain circumstances when coverage would otherwise end under any of the plans offered through the Office of Group Benefits (hereinafter referred to as “Plan” or “Plans”), including the United Health Care Exclusive Provider Plan of Benefits (EPO), the Preferred Provider Plan of Benefits (PPO) and the Humana Health Maintenance Plan of Benefits (HMO). **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice supersedes all other Initial/General COBRA Notices provided to you.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered by the State of Louisiana (such as life insurance).

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should get a copy of the Plan Document from the Plan. The Plan provides no greater rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA’s requirements.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Office of Group Benefits, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below). Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the entire cost of COBRA coverage.

Who Is Entitled to Elect COBRA Coverage?

If you are an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce. If you notify the Office of Group Benefits within 60 days after the divorce and can establish that the employee cancelled the coverage earlier in anticipation of the divorce, the COBRA coverage may be available for the period after the divorce.

A person enrolled as the employee’s dependent child will be entitled to elect COBRA if he or she loses group health

coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries only after the Office of Group Benefits has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the participant employer must notify the Office of Group Benefits of the qualifying event within 30 days following the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Office of Group Benefits in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you can obtain a copy of this form from the Office of Group Benefits at no charge, or you can download the form at www.groupbenefits.org), and you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the Office of Group Benefits during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Electing COBRA

Once the Office of Group Benefits receives timely notice that a qualifying event has occurred, each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children. **Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

Qualified beneficiaries who are entitled to elect COBRA coverage may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA coverage is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA coverage, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied).

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction in hours. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Extension of COBRA Coverage

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's Plan Document. There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration (or by the staff of the Office of Group Benefits in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment) to be disabled on the date the Covered Person became eligible for continued coverage or within the initial 18 months of coverage, and you notify the Office of Group Benefits in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

For persons eligible to receive Social Security disability benefits, the disability extension is available only if you notify the Office of Group Benefits in writing and submit a copy of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

For persons ineligible to receive Social Security disability benefits due to insufficient "quarters", the disability extension is available only if you submit to the Office of Group Benefits in writing proof of total disability before the initial 18-month COBRA coverage period ends.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction in hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from the Office of Group Benefits at no charge, or you can download the form at www.groupbenefits.org), and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the Office of Group Benefits during the 60-day notice period and within 18 months after the employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Office of Group Benefits. This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if you notify the Office of Group Benefits in writing of the second qualifying event within 60 days after the later of:

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still an employee covered under the Plan).

In providing this notice, you must use the Plan's form, entitled "Notice of Second Qualifying Event Form," (you may obtain a copy of this form from the Office of Group Benefits at no charge, or you can download the form at

www.groupbenefits.org), and you must follow the procedures specified in the box at the end of this notice entitled “Notice Procedures.” If these procedures are not followed or if the notice is not provided in writing to the Office of Group Benefits within the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during COBRA period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child’s COBRA coverage begins on the child’s date of birth, date of adoption, or date of placement for adoption if the child is enrolled in the Plan through special enrollment, or on the first day of the following plan year if the child is enrolled through open enrollment. The COBRA coverage lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Office of Group Benefits during the covered employee’s period of employment with the participant employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the Contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the Office of Group Benefits informed of any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Office of Group Benefits.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage upon request from:

**Office of Group Benefits
Eligibility Department
Post Office Box 66678
Baton Rouge, Louisiana 70804**

**Office Telephone: 225.925.6934
Fax: 225.925.4074**

COBRA Notice Procedures

Warning: *If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).*

Notice Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above this notice, and you may obtain copies from the Office of Group Benefits without charge or download them at www.groupbenefits.org. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices: You must mail or hand-deliver your notice to:

**Office of Group Benefits
Eligibility Department
Post Office Box 66678
Baton Rouge, Louisiana 70804**

**Office Phone: 225.925.6934
Fax: 225.925.4074**

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage" and "Second qualifying event extension of COBRA coverage".)

Information Required for All Notice: Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce, your notice must include a copy of the decree of divorce. If your coverage is reduced or eliminated and later a divorce occurs, and if you are notifying the Office of Group Benefits that your Plan coverage was reduced or eliminated in anticipation of the divorce, your notice must include evidence satisfactory to the Office or Group Benefits that your coverage was reduced or eliminated in anticipation of the divorce.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce, a copy of the decree of divorce.

Who May Provide Notice: The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Notice of Medicare Part D Creditable Coverage

IMPORTANT NOTICE FROM THE OFFICE OF GROUP BENEFITS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Office of Group Benefits and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All such plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Office of Group Benefits has determined that the prescription drug coverage offered by all its plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, OGB provides what Medicare calls “Creditable Coverage.”

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Those leaving OGB coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current OGB coverage, including which drugs are covered, with the coverage and cost of plans offering Medicare prescription drug coverage in your area.

Your current OGB coverage also pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you drop your Office of Group Benefits coverage and enroll in a Medicare prescription drug plan, be aware that you may not be able to get the OGB coverage back later.

You should also know that if you drop or lose your coverage with the Office of Group Benefits and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare’s prescription drug coverage, your monthly premium will go up at least one percent per month for every month that you did not have that coverage.

For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage, contact any of the OGB Customer Service offices. You will receive this notice at other times in the future such as the next period in which you can enroll in Medicare prescription coverage, and if this coverage changes. You also may request a copy.

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More detailed information about Medicare plans that offer prescription drug coverage is also available in the *Medicare & You* handbook. You will get a copy of the handbook in the mail from Medicare. You may be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these sources:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare that offer prescription drug coverage, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

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