



SUMMARY PLAN DESCRIPTION

for the

LaCHIP Affordable Plan

Sponsored by the
State of Louisiana

through the
Department of Health and Hospitals (DHH)

Benefits Administered by the
Louisiana Office of Group Benefits (OGB)

Revised September 2010

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for the
LaCHIP Affordable Plan
2010-2011

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LEVEL 1 SCHEDULE OF BENEFITS – LaCHIP Affordable Plan

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

Lifetime Maximum for all Benefits, including Outpatient Prescription Drug Benefits, Mental Health and Substance Abuse Benefits, per person	\$ 5,000,000
Deductible	None

Percentage Payable

Eligible Expenses incurred for services of a participating Provider	90%
Eligible Expenses incurred for services of a non-participating Provider	70%
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 out-of-pocket threshold.**
- **Eligible expenses of non-participating providers are based upon OGB's Fee Schedule.**

There may be a significant out-of-pocket expense 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	100%
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PRESCRIPTION DRUG BENEFITS

Network Pharmacy

Member pays 50% of drug costs at point of purchase up to a maximum co-payment of \$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

Questions about prescription drug benefits should be directed to Catalyst Rx by calling the telephone number listed on your LaCHIP Affordable Plan ID card.

WELL CARE

Well Baby

Birth until Age 1

All office visits for scheduled immunizations and screenings*

Well Child

Ages 1 and 2

Three office visits, including scheduled immunizations and screenings, per Plan Year*

Ages 3 through 15

One office visit, including scheduled immunizations and screenings, per Plan Year*

Well Adult

Ages 16 through 18

All eligible well care expenses*

* Participating Providers are reimbursed at 100% of Eligible Expenses up to the maximum benefit; Non-participating Providers are reimbursed at 70% of Eligible Expenses up to the maximum benefit.

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 benefits are listed in Article 2, Section I (24).

Questions about medical and wellness benefits should be directed to OGB Customer Service by calling the telephone number listed on your LaCHIP Affordable Plan ID card.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

(Requires prior approval of services)

Benefits

Eligible expenses incurred for services of a participating provider	90%
Eligible expenses incurred for services of a non-participating provider	70%
Eligible expenses in excess of \$10,000 per plan year, per person	100%

Note: Eligible expenses of a participation provider are based upon contracted rates. Participation provider discounts are not eligible expenses and do not apply to the out-of-pocket threshold.

Eligible expenses of non-participating providers are based upon OGB’s fee schedule.

Expenses incurred for emergency services will be reimbursed only if, after review, the services are determined to be a life-threatening psychiatric emergency resulting in an authorized mental health or substance abuse admission within 24 hours to an inpatient, partial, or intensive outpatient level care. Non-emergent psychiatric or substance abuse problems treated in the emergency room will not be eligible for reimbursement.

There may be a significant out-of-pocket expense when using a non-participating provider!

Questions about mental health and substance abuse treatment benefits should be directed to United Behavioral Health by calling the telephone number listed on your LaCHIP Affordable Plan ID card.

LEVEL 0 SCHEDULE OF BENEFITS – LaCHIP Affordable Plan

Benefits will be paid at 100% (without co-pays or co-insurance).

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.

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

Benefit Payment means payment of Eligible Expenses due or owing by a Covered Person, co-payments, and co-insurance, 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.

Convalescent /Maintenance Care or Rest Cures 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 Services refers to those health care services for which a Covered Person is entitled to receive Benefit Payments in accordance with to 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.

DHH means the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing

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 in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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.

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

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

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.

LaCHIP Affordable Plan means the plan described herein may be referred to as the Plan and/or Program.

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 Provider means a medical provider who has entered into a contractual agreement with the Program to provide medical services to Covered Persons at a reduced or discounted price.

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 health 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 Year means the period from July 1, or the date the Covered Person first becomes covered under the Plan, through the next following June 30. Each successive Plan Year will be the twelve month period from July 1 through the next following June 30.

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.

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.

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 Covered Person is responsible. This amount does not include any ineligible expenses. The Covered Person'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.

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.

Well Adult Care applies to covered persons age 16 through attainment of age 19 and means a routine physical examination by a physician that may include an influenza vaccination, lab work, and x-rays performed as part of the exam in that physician's office, when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as Well Adult Care.

Well Baby Care applies to covered persons from birth until age 1 and means routine care to a well newborn infant that may include physical examinations and active immunizations provided by a physician when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as Well Baby Care.

Well Child Care applies to covered persons from age 1 through age 15 and means routine physical examinations and active immunizations provided by a physician, when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedure and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as Well Child Care.

ARTICLE 1 **ELIGIBILITY**

I. PERSONS TO BE COVERED

Eligibility requirements are defined and maintained by DHH and apply to all participants in the program.

II. TERMINATION OF COVERAGE

Coverage will terminate under this plan upon termination of eligibility by DHH.

ARTICLE 2 **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 co-payments and/or co-insurance 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, 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 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. The first two pairs of surgical pressure support hose. Additional surgical support hose may be considered an Eligible Expense at the rate of one pair per six-month period;
17. The first two ortho-mammary surgical brassieres. Additional ortho-mammary surgical brassieres may be considered an Eligible Expense at the rate of one per six-month period;
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 (29) of this section.

23. Preventive care consisting of routine physical examinations, lab work, and immunizations (including a yearly influenza vaccination) as follows:

a. Well Baby Care expenses:

- i. Newborn facility and professional charges;
- ii. Birth until Age 1 – all office visits for scheduled immunizations and screenings;

b. Well Child Care expenses:

- i. Ages 1 and 2 – three office visits per year for scheduled immunizations and screenings;
- ii. Ages 3 through 15 – one office visit per year for scheduled immunizations and screenings;

c. Well Adult Care expenses:

- i. Ages 16 through 18 – during a 3-year period

Note: Benefits for well baby and well child care and routine physical examinations for adults, including immunizations, are based on the U.S. Preventive Services Task Force guidelines and recommendations of the National Immunization Program of the Centers for Disease Control and Prevention. All services are rendered on an outpatient basis to monitor and maintain health and to prevent illness.

24. Specialized age appropriate wellness care as follows:

a. One Pap test for cervical cancer per Plan Year

25. Outpatient surgical facility fees as specified in the maximum payment schedule;

26. 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;

27. 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;

28. Oxygen and oxygen equipment;

29. 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.
30. 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.
31. 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.
32. Hearing aids for use by a Covered Person, 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.
33. 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;

II. FEE SCHEDULE

- A. The Fee Schedule establishes the maximum allowable charges for Eligible Expenses. The Fee Schedule applies to both contracted health care providers, who have entered into agreements with OGB regarding reimbursement under this plan, and to non-contracted 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-contracted facilities.
 - 2. It is the Provider's responsibility to obtain PAC for contracted facilities. If the Provider fails to do this, the Plan Member cannot be billed for any amount not covered by this Plan.
- B. 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.
- C. Benefits otherwise payable for services at a non-contracted 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-contracted Provider.
 - 2. On services performed by a contracted 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 2, Section I (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 or hyperbaric oxygen 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 2, 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 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 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 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. 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 2, 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 2, Section I (27), 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. 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;
 11. 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;
 12. Services, supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed Medically Necessary by the Program;
 13. 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;
 14. Services and supplies for the treatment of and/or related to gender dysphoria or reverse sterilization;
 15. 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;
 16. Expenses 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;
 17. 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;
 18. Administrative fees, interest, penalties, or sales tax;
 19. Marriage counseling, family relations counseling, divorce counseling, parental counseling, job counseling, and career counseling;

20. Charges for Physician services rendered to a Covered Person over the telephone or in a non-face-to-face setting;
21. Radial keratotomy, laser surgery, and any other procedures, services, or supplies for the correction of refractive errors of the eyes;
22. 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.
23. Hearing aids and any examination to determine the fitting or necessity of hearing aids, except as specifically provided for in Article 2, Section I (32);
24. Hair plugs and/or transplants;
25. Routine physical examinations and/or immunizations not provided for under Eligible Expenses;
26. Routine eye examinations, glasses, and contact lenses, except as specifically provided for as an Eligible Expense in Article 2, Section I (15);
27. Diagnostic or treatment measures that are not recognized as generally accepted medical practice;
28. Medical supplies not listed under Eligible Expenses;
29. 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;
30. Molecular laboratory procedures related to Genetic Testing except when determined to be Medically Necessary for histocompatibility/blood typing, neoplasia, hereditary disorders, or other conditions approved in advance by OGB ;
31. Services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.);
32. Services rendered by a Physician or other health care Provider related to the patient by blood, adoption, or marriage;
33. 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;
34. 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;
35. Glucometers;
36. Augmentative communication devices;
37. Charges to obtain medical records or any other information needed and/or required to adjudicate a claim;
38. Charges greater than the global allowance for any laboratory, pathology, or radiological procedure.
39. Speech therapy or the services of a speech therapist except as specifically provided in Article 2, Section I (9).

IX. 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;
 - 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 co-insurance 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. Amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy;
 5. Nicotine, gum, patches, or other products, services, or programs intended to assist an individual to reduce or cease smoking or other use of tobacco products;
 6. Nutritional or parenteral therapy;
 7. Vitamins and minerals;
 8. Drugs available over the counter;
 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;
 11. 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:

Level 1 Benefits

1. Upon presentation of the LaCHIP Affordable Plan Health Benefits Identification Card at a network pharmacy, the covered person will be responsible for payment of 50% of the cost of the drug, up to a maximum of \$50 dollars per 30-day prescription dispensed. The Plan will pay the balance of the eligible expense for prescription drugs dispensed at a network pharmacy. There is a \$1200 per person per Plan Year out-of-pocket threshold for eligible prescription drug expenses. Once this threshold is reached by the covered person paying \$1200 of co-insurance/co-payments for eligible prescription drug expenses, the covered person 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.
2. In the event the Covered Person does not present his/her identification card to the network pharmacy at the time of purchase, the Covered Person will be responsible for full payment for the drug and must then file a claim with the prescription benefits manager for reimbursement. Reimbursement is limited to the rates established for non-network pharmacies.
3. If the Covered Person obtains a prescription drug from a non-network pharmacy in state, reimbursement will be limited to 50% of the amount that would have been paid if the drug had been dispensed at a network pharmacy. If the Covered Person obtains a prescription drug from a non-network pharmacy out of state, benefits will be limited to 80% 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 the prescription benefits manager's maximum allowable charge for the drug dispensed.
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 Covered Person will be responsible for payment of 50% of the cost of the drug, up to a maximum of \$50 per prescription dispensed;
 - ii. For a supply of 31-60 days, the Covered Person will be responsible for payment of 50% of the cost of the drug, up to a maximum of \$100 per prescription dispensed;
 - iii. For a supply of 61-90 days, the Covered Person will be responsible for payment of 50% of the cost of the drug, up to a maximum of \$150 per prescription dispensed;
 - iv. Once the out-of-pocket threshold for eligible prescription drug expenses is reached, the Covered Person's co-payment responsibility for brand drugs will be \$15 for a 1-30 day supply, \$30 for a 31-60 day supply, and \$45 for a 61-90 day supply, with no co-pay for up to a 90 day supply of generic drugs.
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.

Level 0 Benefits

The plan will pay 100% of eligible expenses for outpatient prescription drugs.

ARTICLE 3
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 Person, constitute the entire agreement between the parties.

II. PROPERLY SUBMITTED CLAIM

A. For Plan reimbursement, a claim must include:

1. Name of patient;
- 2.. Patient's date of birth and address
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. Covered Person's member number;
9. Provider's tax identification number; and
10. Provider's NPI number.

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 Covered Person 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 Covered Person 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 supersede and control.

VI. 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.

VII. 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 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 Person, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a Covered Person, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made. To this end, 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.

VIII. D.H.H. RESPONSIBILITY

It is the responsibility of DHH to submit enrollment and change forms and all other necessary documentation to the Program on behalf of its Covered Persons. Employees of DHH 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.

IX. 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.

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

OGB has the statutory responsibility of providing health and accident and death benefits to the covered dependent 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 Covered Person.

ARTICLE 4 **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

The parent of 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. the 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 60 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 parent of a 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
 - a. 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.
 - b. The OGB Medical Director shall serve as a member of the Committee and shall consult a health care provider with appropriate expertise in the matter under review as necessary.
- 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 on behalf of 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.
 - 3. The Committee will render its decision within 60 days after receipt of the written request for review.
- E. The parent of a Covered Person who disagrees with the Committee's decision may request further review by submitting a letter or form to DHH.

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.