

Table of Contents

Title 32 EMPLOYEE BENEFITS

Part I. General Provisions

Chapter 1.	General Information	1
Chapter 3.	Entrance into the Program	1
Chapter 5.	School Systems.....	2
Chapter 7.	Election Rules and Regulations.....	5
Chapter 9.	Criteria for Participation in a Preferred Provider Organization, Exclusive Provider Organization, or Other Managed Care Arrangement	8
Chapter 11.	Contributions	9
Chapter 13.	Cost Assessment and Allocation	10

Part III. Preferred Provider Organization (PPO)C Plan of Benefits

Chapter 1.	Eligibility	11
Chapter 2.	Termination of Coverage.....	17
Chapter 3.	Medical Benefits.....	17
Chapter 4.	Uniform Provisions	25
Chapter 5.	Claims Review and Appeal	27
Chapter 6.	Definitions	29
Chapter 7.	Schedule of BenefitsCPPO	32

Part V. Exclusive Provider (EPO)C Plan of Benefits

Chapter 1.	Eligibility	35
Chapter 2.	Termination of Coverage.....	41
Chapter 3.	Medical Benefits.....	41
Chapter 4.	Uniform Provisions	49
Chapter 5.	Claims Review and Appeal	51
Chapter 6.	Definitions	53
Chapter 7.	Schedule of BenefitsCEPO	56

Part VII. Public Employees Deferred Compensation

Chapter 1.	Administration	59
Chapter 3.	Plan Participation, Options and Requirements.....	62
Chapter 5.	Investments	64
Chapter 7.	Distributions	65
Chapter 9.	Leave of Absence	69
Chapter 11.	Participant Loans	69

EMPLOYEE BENEFITS

Chapter 13. Plan Amendment or Termination 70
Chapter 15. Taxes, Nonassignability and Disclaimer 71
Chapter 17. Employer Participation 72
Chapter 19. Applicable Terms 72

Part IX. Health Maintenance OrganizationsCHMO

Chapter 1. General Provisions..... 73
Index 77

Title 32
EMPLOYEE BENEFITS
Part I. General Provisions

Chapter 1. General Information

§101. Organizational Description Purpose of Agency

A. The Board of Trustees of the State Employees Group Benefits Program was created within the Department of the Treasury Act of 745 of 1979. This Board, domiciled in Baton Rouge, Louisiana, is responsible for the general administration of all aspects of programs constituting the State Employees Group Benefits Program, as provided in Part I and Part II of Chapter 12 of Title 42 of the Louisiana Revised Statutes of 1950.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980).

Chapter 3. Entrance into the Program

§301. Admission

A. Groups enrolling in the State Employees Group Benefits Program must submit the following information and agree to the following conditions. These groups must:

1. complete and adoption instrument, which instrument must be received by the executive director prior to the mutually agreed upon effective date of coverage;
2. submit a complete list of employees providing name, social security number, sex, date of birth, date of employment, dependency class, salary, and indication of prior coverage. One such list for active employees, and another for retired employees receiving retirement income under an approved state retirement program;
3. provide a statement of experience on the attached from;
4. provide a certified copy of the board resolution or authority to enter into negotiations for coverage;
5. agree to pay the program any terminal reserves or refunds that might be available now or in the future from their present plan;
6. acknowledge that before benefits become effective that the enrollment of employees must be completed with a participation level of at least 85 percent of the plan members who had participated in the previous plan. Enrolling groups must further acknowledge that should its participation level at any time following the initial enrollment fall below 50 percent of its eligible employees, the board may, in its sole discretion, discontinue the coverage for the group;

7. accept the whole plan of benefits, including the health and accident coverage and the full schedule of life insurance benefits. The board may, in its sole discretion, discontinue the coverage of the those groups whose participation level falls below 50 percent of eligible employees.

B. In determining the participation level of employees and eligible dependents, the following classification of dependents shall not be included in calculating the participation level:

1. dependents who are covered by any other group type major medical coverage;
2. dependents of active or retired military personnel covered by military medical benefits;
3. dependents covered by Medicaid or Medicare or their successor programs;
4. dependents whose coverage is declined based on religious convictions.

C. The board, for purposes of establishing rates and premiums, may group risks into one or more classification. The rates and premiums adopted for each classification shall take into consideration the loss experience in the classification, as well as other relevant factors. If a school board elects to participate in the state group health and accident insurance program after participation in another group health and accident program, the premium rate applicable to teachers and other school board employees and former employees intended to be covered by the program shall be the greater of the premium rated based on the loss experience of the group under the prior plan or the premium rate based on the loss experience of the classification into which the group is entering and shall be for a period of no longer than one year. The rates so fixed shall not be excessive, inadequate, or unfairly discriminatory, and shall be uniform within each classification.

D. There shall be no pre-existing condition limitations on the group's employees who enroll for coverage during the open-enrollment period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended LR 2:494 (September 1982), LR 17:892 (September 1991).

§303. Eligibility

A. For the purpose of determining eligibility to participate in the State Employees Group Benefits Program the term "retiree" shall refer only:

1. to those persons who, prior to retirement, were participating in the State Employees Group Benefits Program and who, at the date of retirement were not subject to either the three month/one year, or one year/two year preexisting condition provisions of the plan and who, upon retirement:

a. were immediately eligible to receive a retirement stipend from the retirement system of a political subdivision or agency whose active members are eligible to participate in the State Employees Group Benefits Program; or

b. were not actually eligible to participate in said retirement system but have completed ten years of service and have attained at least 65 years of age;

2. to such other persons now retired who, on the effective date of this resolution, are eligible or agency whose active members are eligible to participate in the State Employees Group Benefits Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980).

Chapter 5. School Systems

§501. General Provisions

A. Those school groups who were participating in the State Employees Group Benefits Program prior to September 1, 1979, and who wish to be considered "state employees" for the purposes of the State Employees Group Benefits Program, must agree to the following conditions:

1. Complete a new Adoption Instrument, which instrument must be received by the Executive Director no later than sixty days prior to the proposed effective date.

2. Provide a complete list of employees giving name, Social Security number, sex, date of birth, date of employment, dependency class and salary (salary at date of retirement for eligible retired employees). One such list for active employees and another for retired employees receiving retirement income under an approved state retirement program.

3. A copy of the board resolution or authority to enter into the negotiations for coverage.

4. Acceptance of an effective date as outlined in their Adoption Instrument, at which time such plan will be administered exactly as if the employees were State employees.

5. Acknowledgment that the enrollment of active and retired employees not now covered, must be completed with medical coverage for overdue active employees and dependents subject to the one year/two year preexisting condition rule. Evidence of insurability will be waived on the life insurance.

6. The definition of retired employees shall include:

a. all retired employees and their eligible dependents and eligible surviving spouses;

b. such retired employees or surviving spouses must be receiving retirement disability, or survivor's benefits from one of the State retirement plans;

c. the offering of such coverage shall be made at a time at least sixty days after receipt of a completed new Adoption Instrument on a one-time offering basis. No retired employee will be allowed thereafter to participate who does not make application when first eligible.

B. Those school boards having a local group policy or program in effect for school board employees and retirees prior to September 1, 1979, and who are seeking approval of said program to be eligible for a partial reimbursement of premiums must submit the following nonexclusive documentation and consent to the following nonexclusive certifications prior to approval:

1. the school system must provide the State Employees Group Benefits Program with a complete copy of the present insurance policy or policies and premium rate structure for each;

2. the effective date of said insurance plan must be prior to September 1, 1979. The Superintendent of the local school board must certify, before an officer qualified to administer oaths, that the submitted policy or policies were in effect prior to September 1, 1979;

3. the present school board seeking approval of the policy or policies must present proper data relative to covered employees and the amount of said coverage;

4. all retirees and surviving spouses of retired employees of said school system must be offered coverage in the submitted insurance policy or policies on an equal basis with active employees;

5. the local school board seeking acceptance of the policy or policies must agree, in writing, to an annual audit of their insurance program by the State Employees Group Benefits Program or its designee;

6. the local school board seeking approval of its policy or policies must agree to provide the State Employees Group Benefits Program with a monthly breakdown of changes in coverage of employees. Such a breakdown shall include, but not be limited to, the total number of changes within any classification in the names and social security numbers of employees affected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended LR 9:763 (November 1983).

§503. Guidelines for Partial State Premium Reimbursement

A. In order to be eligible for partial state premium reimbursement as provided for in Act 745 of 1979, each school board which contracts with a private insurance carrier for medical or life insurance coverage for its employees, or which provides such coverage on a self-insured basis, shall comply with the following guidelines:

1. Nature of the Contract. It is required that all private policies of health and life insurance adopted by a school board be true group contracts, in accordance with Part VI, of Title 22 of the Louisiana Revised Statutes of 1950 or self-funded plans. In order that this may be determined, each board shall be required to submit to the Group Benefits Program copies of all contract documents, including any amendments as may be adopted from time to time.

2. EligibilityCActive Employees. Only full-time employees of the school board and their dependents shall be eligible for coverage. A full-time employee is defined as an employee who works 30 hours or more per week: provided, however, that an employee whose full-time occupation normally requires less than 30 hours per week shall be considered also a full-time employee. Eligible dependents shall include the employee's legal spouse and unmarried children as authorized by the insurer.

3. Effective Dates of CoverageCActive Employees. Coverage shall become effective on the first of the month coinciding with or next following the completion of one calendar month's employment provided that the employee has made a written request for coverage by completing the applicable enrollment form(s) and has agreed to make any required contribution for his coverage. Dependent coverage shall become effective on the date the employee becomes eligible or acquires the dependent, whichever is later. Request for coverage submitted beyond 30 days from date of employment or the acquisition of an eligible dependent shall be subject to the provisions of Paragraph 8, Pre-Existing Conditions.

4. EligibilityCRetirees

a. Each retired employee of the School Board shall be eligible for coverage provided the retired employee meets the following requirements:

i. was a covered employee on the school board's contract immediately prior to the date of retirement; and

ii. upon retirement, immediately received retirement benefits from one of the approved State of Louisiana Retirement Systems: or if not eligible for participation in such a plan, has ten years of continuous service and has reached the age of 65.

b. Eligible dependents of retired employees shall include the retiree's legal spouse and unmarried dependent children as authorized by the insurer.

5. Effective Dates of CoverageCRetirees. Coverage for retired employees and their dependents shall be effective on the first of the month following date of retirement if the employee and his dependents were covered immediately prior to retirement. Coverage for dependents of retirees first becoming eligible for coverage following the date of retirement shall be effective on the date of marriage (for new spouses of retirees), the date of birth (for newborn children of retirees) or the date of acquisition (for other classifications of dependents) if application is made within 30 days of the date of eligibility. Dependents of retirees shall not be eligible for coverage as late applicants.

6. Employment after Retirement. An employee retired from one school board may be covered as an active employee of another school board, or as a retiree of the board from which he retired, but not both. Upon termination of employment from the latter school board, the employee may return to the retired employee coverage of his original employer board.

7. Late Applicants. A late applicant shall be considered, in the case of an active employee, as one who makes application for coverage after 30 days from the date he becomes eligible. In the case of a dependent, a late applicant shall be considered as one for whom application for coverage is made after 30 days from the date such dependent is eligible or acquired. Late applicants shall be subject to the terms and provisions of Paragraph 8 hereafter. Retirees and their dependents shall not be eligible for coverage as late applicants.

8. Pre-Existing Conditions. Active employees of a school board and their dependents who are considered late applicants may be enrolled for coverage only under the following circumstances.

a. Eligible active employees may be enrolled in the life insurance program of the school board on the first day of any month upon submission of a statement of health and approval thereof by the company insuring the life program for the school system.

b. Eligible active employees and their dependents may enroll in the health insurance program on the first day of the month subject to the following pre-existing condition stipulation: A physical injury or sickness will be considered a pre-existing condition if treatment was received or if drugs were prescribed or taken during the 12 consecutive month period immediately preceding the effective date of coverage. No benefits will be payable for a pre-existing condition until the covered person has been a participant in the plan for 24 consecutive months.

9. Continuation of Coverage. In the event of the death of a covered active or retired employee, surviving covered dependents of the employee shall be allowed to continue participation in the school board's group accident and health coverage subject to the following conditions.

a. The surviving legal spouse of a deceased active or retired employee may continue coverage until eligible for participation in an employer-sponsored medical plan or until remarriage, whichever occurs first.

b. Surviving children of a deceased active or retired employee may continue coverage until eligible for an employer sponsored medical plan or attainment of the termination date for children as set forth in the school board's contract, whichever occurs first.

10. Change of Carrier. In the event a school board changes the carrier for its health and/or life insurance coverage, or amends the coverage provisions of its existing contract(s), neither the installation of a new contract nor an amendment to an existing contract shall nullify the definition of a "late applicant" as defined in Paragraph 7, and an

EMPLOYEE BENEFITS

employee or dependent who is subject to the limitations governing pre-existing conditions (Paragraph 8) shall remain so.

11. Transfers. A covered active employee who terminates employment with a school board and is immediately employed by another board shall not be required to serve the eligibility period required of a new employee, and coverage on the latter board's contract shall be continuous for such employee and his dependents. Any limitations for Pre-Existing Conditions which may be applicable to the employee's coverage under the predecessor board's contract shall carry forward to the successor contract.

12. Information to be Furnished. In order that the amounts for partial state premium reimbursement may be determined, the school board shall be required to furnish to the Program the information set forth in Appendix A.

Appendix A

A. Data to be furnished annually:

I. Separate alphabetized lists by last name of participants in each of the following classifications:

- 1. Active employees
2. Retired employees
3. Surviving spouse of retired employees
4. School board members

Lists to include:

A. Social Security number (on list of surviving spouses, only the Social Security number of deceased employee)

B. Date of birth

C. Annual or hourly salary (if employee is retired, salary as of retirement date), exclude if surviving spouse

D. Amount of life insurance coverage (on employee only) for each life carrier

E. Amount of accidental death and dismemberment coverage (on employee only), for each life carrier, exclude if surviving spouse

F. Type of medical coverage according to these classifications:

- 1. No health coverage
2. Employee only
3C. Employee and one dependent (child)
3S. Employee and one dependent (spouse)
4C. Employee and two or more dependent children
4S. Employee and two or more dependents (family)
5. Employee only, with Medicare
6C. Employee with Medicare and one dependent (child) without Medicare
6S. Employee with Medicare and one dependent (spouse) without Medicare
7C. Employee without Medicare and one dependent (child) with Medicare
7S. Employee without Medicare and one dependent (spouse) with Medicare
8C. Employee with Medicare and one dependent (child) with Medicare
8S. Employee with Medicare and one dependent (spouse) with Medicare
9C. Employee with Medicare and two or more dependents (children) without Medicare
9S. Employee with Medicare and two or more dependents (family) without Medicare
IOC. Employee without Medicare and two or more dependents (children) one dependent with Medicare
10S. Employee without Medicare and two or more dependents (family) one dependent with Medicare

- 11 C. Employee with Medicare and two or more dependents (children) one dependent with Medicare
11S. Employee with Medicare and two or more dependents (family) one dependent with Medicare.

NOTE: If rates do not vary according to dependent coverage, C and S codes are omitted.

G. Notation of:

- 1. Employees on leave without pay - LWOP
2. Federally funded employees - Fed. Fund - indicate percentage of salary paid with Federal Funds
3. Federally funded employees - Fed. Fund - indicate percentage of insurance premiums paid with Federal Funds

Important: The lists compiled by the school board must conform to these classifications regardless of current policy classifications.

II. Premium rates by classification for life and medical coverage and also current billing basis (9 month. 10 month. 12 month).

III. A copy of all private group insurance invoices.

IV. A copy of the school board's budget for the current Fiscal Year.

V. A schedule providing the budgeted salary information shown below.

NOTE: Do not include 1. school bus drivers' operational expenses, 2. part-time salaries, and 3. substitute teachers' salaries.

- a. Total amount of federally funded active school system employees salaries
b. Total amount of non-federally funded active school system employees salaries
c. Total amount of budgeted salaries for current Fiscal Year.

VI. A schedule providing the following actual expenditure data for the Fiscal Year. This information must be received by July 10 of each year for the fiscal ending the previous June 30.

NOTE: Do not include 1. school bus drivers' operational expenses, 2. part-time salaries, and 3. substitute teachers' salaries.

- a. Fiscal Year cost of federally funded salaries of active employees.
b. Fiscal Year cost of non-federally funded salaries of active employees.
c. Total fiscal cost of salaries of active employees for the Fiscal Year ending the previous June 30.

VII. The participation classification lists will be reconciled to the insurance invoices, and all work papers will be provided to this agency.

The above information is needed by September 30 annually with the exception of actual salary information which is needed by July 10 as stated in number VI.

B. The following information is needed monthly:

I. Separate alphabetized exception lists by last name indicating:

- a. New Participants
b. Participants canceling coverage
c. Participants increasing coverage
d. Participants decreasing coverage
e. Changes in status of federally funded employees
f. Information required to monitor as listed below, per open enrollment resolution dated 6-30-81.

Table with 2 columns: Type of Application, Information Required. Rows include: 1. New Employees, A. Life Insurance, B. Health Insurance.

II. Employees presently enrolled for group insurance who request change(s) in their coverage.

A. Life Insurance Copy of the Statement of Health form with approval of insurer affixed thereto for employees increasing life from basic to supplemental.

B. Health Insurance
 a. Application made within 30 days of the date the dependents become eligible for coverage in accordance with the provisions of the school board's insurance policy or self-funded program.
 1. Date of application
 2. Date of eligibility of dependent(s)
 b. Application made 31 days or longer after the date the dependent(s) become eligible for coverage.
 1. Date of application
 2. Date of eligibility of dependent(s)
 3. Copy of Evidence of Insurability form subject to P.E.C. limitation with insurer's approval affixed thereto
 or
 Certification of insurer that dependent(s) have submitted Evidence of Insurability forms and that insurer has approved them for coverage subject to P.E.C. limitation.

III. Employees who did not enroll for coverage within 30 days of their employment who now wish to enroll.

A. Life Insurance Copy of the Statement of Health form with approval of insurer affixed thereto.

B. Health Insurance
 1. Date of application
 2. Date of employment of individuals desiring to enter the group plan
 3. Copy of Evidence of Insurability form subject to P.E.C. limitation with insurer's approval affixed thereto
 or
 4. Certification of insurer that employee has submitted Evidence of Insurability form and that insurer has approved employee for coverage subject to P.E.C. limitation.

13. Miscellaneous. The Board of Trustees of the State Employees Group Benefits Program authorizes the Executive Director to establish any administrative procedures and to require any additional information from the school board as may be necessary to efficiently administer the premium reimbursement provisions of R.S. 42:851 and R.S. 42:821, as amended.

14. The school boards need to submit the information schedule above to the Program within 60 days of the application for coverage. The reimbursements to the school boards do not include funds for the above three categories of application until the required information is received.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 8:22 (May 1983), amended LR 9 (May 1983).

Chapter 7. Election Rules and Regulations

§701. Composition of Board of Trustees

A. An election will be held to elect one Board member from the ranks of, and to represent:

1. the Department of Transportation and Development for a term of one year;
2. the Department of Health and Human Resources for a term of two years;
3. the Office of the Governor and the Division of Administration for a term of three years;
4. the personnel of the public institutions of higher education for a term of three years;
5. the teachers and other personnel of the elementary and secondary education system of the State for a term of four years;
6. a retired State employee to represent the State retirees for a term of two years;
7. all other employees participating in the Program (at large candidates) that are not teachers and other personnel of the elementary and secondary education system, personnel of the public institutions of higher education, personnel of the Department of Health and Human Resources, the Office of the Governor and the Division of Administration, or a retired State employee, for a term of four years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980).

§703. Candidate Eligibility

A.1. A candidate for a position on the Board of Trustees must be a participant in the Program as of the specified membership date.

2. If elected, the Board member must continue to be a participant in the Program during his tenure on the Board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:1200 (May 1980).

§705. Petitions for Candidacy

A. To become a candidate, a person must be nominated by petition of twenty-five or more participants in the State Employees Group Benefits Program from the ranks of the employees they will represent

B. The petitioning participants' signature must be accompanied by their Social Security Number.

EMPLOYEE BENEFITS

C. Each Petition for Candidacy must be signed by the appropriate agency head or his designated representative from a candidate's agency certifying that each candidate and each petitioner is a plan participant from the ranks of employees they will be representing, and an active plan member on the specified membership date.

D. Petitions for Candidacy must be in the office of the State Employees Group Benefits Program on or before the date indicated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980).

§707. Ballot Preparation and Distribution

A. Ballot positions of candidates will be determined by a drawing.

B. All candidates ME be notified of the time and place of the drawing.

C. All candidates or his/her representative may attend the drawing.

D. Except for State retirees, ballots and information sheets on candidates will be distributed to each assigned Group Benefits Invoice Coordinator (agency contact) for distribution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980).

§709. Balloting Procedure

A. All participants enrolled in the Group Benefits Program on the specified membership date are eligible to vote.

B. A ballot will be distributed to all eligible Group plan participants by the Group Benefits Invoice Coordinator, except State retirees.

C. Each eligible plan member may cast only one vote for any candidate listed on the ballot

D. Ballots must be returned in envelope provided.

1. Signature of the voting member must appear on the official ballot envelope for comparison with the records of the system.

2. Envelopes containing more than one ballot will not be accepted.

3. Ballots must be received in the office of the State Employees Group Benefits Program on, or before, the date indicated.

4. The sealed, postmarked or stamped-received envelope will be placed in the ballot file for opening by the Ballot Counting Committee, thus assuring that only members vote and an absolute secret ballot is maintained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980).

§711. Ballot Counting

A. The Ballots will be counted by the Ballot Counting Committee.

B. The Ballot Counting Committee shall be composed of employees of the State Employees Group Benefits Program, appointed by the Executive Director.

C. The Ballot Counting Committee and all candidates will be notified at the time and date fixed for tallying the ballots.

D. The Ballot Counting Committee will be responsible for the opening, preparation, and counting of the ballots.

E. All candidates or his/her representative may observe the ballot counting procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980).

§713. Election Results

A. The Executive Director will certify the election results to the Board of Trustees.

B. The Board of Trustees will announce the election results at the first regularly scheduled Board meeting following the election.

C. The Board of Trustees will notify the successful candidates of their election.

D. The Board of Trustees will certify the election results to the Secretary of State.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980).

§715. Uniform Election Dates

A. First Monday March C Group Benefits submits nomination sheets to agency's designated invoice coordinator.

B. First Monday April C Nomination cutoff date. Nominees must be certified by their agency before nominations can be accepted by Group Benefits.

C. Second Monday April C Drawing at State Employees Group Benefit Program Office at 2648 Wooddale Boulevard, Baton Rouge, to determine the position each candidate will have on the ballot. All candidates are invited to attend or send a representative.

D. Prior to first Monday in May, Ballots will be sent to proper authority for distribution.

E. Second Monday JuneCOB. Deadlines for receiving ballots in State Employees Group Benefits Program Office.

F. Third Monday JuneC All ballots counted.

G. Election results promulgated at next Board of Trustees meeting following the counting of ballots.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:7122 (March 1981).

§717. Selection of Minority Members

A. Two members of a minority race, as defined below, who are state employees and participants in the State Employees Group Benefits Program will be appointed to the board pursuant to R.S. 42:872 and these rules.

B. The following groups of person are hereby designated as a "minority."

*American Indian or Alaskan Native*Cpersons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation of community recognition.

*Asian or Pacific Islander*Cpersons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent or the Pacific Islands.

*Black*Cnot of Hispanic origin. Persons having origin in any of the black racial groups of Africa.

*Hispanic*Cpersons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish cultures or origin regardless of race.

C. Any interested person meeting the requirements of Subsections A and B may apply for appointment to the Board by forwarding to the chairman of the selected committee:

1. a petition signed by at least 25 state employees who are participants in the State Employees Group Benefits Program. This petition, nominating a minority person for appointment, must contain a certification by the agency head or personnel officer that the persons signing the petition are indeed state employees and participating in the program; and (a sample petition is attached to these rules);

2. a résumé outlining the experience and qualifications of the minority applicant.

D. The petition and résumé must be sent to:

Chairman, Selection
2648 Wooddale Boulevard
Baton Rouge, Louisiana 70805

E. All applications for appointment must be received prior to the close of business on March 31, 1981.

F. The board, or any committee thereof, may interview any or all of the applicants for membership on the Board of Trustees.

G. The two minority persons appointed to the board will serve until September 1, 1984. Minority members appointed subsequent thereto shall serve terms of office concurrent with other members of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:49 (February 1981).

§719. Petition Form

A. Nominating Petition

We the undersigned state employees and participants in the State Employees Group Benefits Program, hereby nominate _____ for membership on the Board of Trustees of the State Employees Group Benefits Program.			
Signature	Social Security Number	Agency	Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
I hereby certify the persons signing this petition are state employees and members of the State Employees Group Benefits Program.			
_____ Agency Chief Officer		_____ Personnel Officer	

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:50 (February 1981).

§721. Severability

A. If any provision or item of these rules or the application thereof is held invalid, such invalidity shall not affect other provisions, items, or applications of these rules which can be given effect without the invalidated provisions, items, or applications and to this end the provisions of these rules are hereby declared severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980).

Chapter 9. Criteria for Participation in a Preferred Provider Organization, Exclusive Provider Organization, or Other Managed Care Arrangement

§901. Notice of Intent to Contract

A. Notice of intent to contract with health care providers, or with groups or organizations of health care providers, on behalf of the State Employees Group Benefits Program, for participation in a preferred provider organization, exclusive provider organization, or other managed care arrangement shall be given by publication in the official journal of the State of Louisiana or by direct solicitation setting forth the Program's intent to contract, describing the services sought, and providing a contact point for requesting a detailed explanation of the services sought and the criteria to be used in developing contracts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:25:859 (May 1999).

§903. Preferred Provider Organization (PPO) Criteria

A. The following criteria shall govern participation in the Program's Preferred Provider Organization (PPO).

1. The health care provider shall be appropriately licensed in accordance with the laws of the state where the services are to be rendered.

2. The health care provider shall accept the reimbursement schedule established by the Program.

3. The health care provider shall execute a PPO contract setting forth the Program's the terms and conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:25:859 (May 1999).

§905. Exclusive Provider Organization Criteria

A. In addition to the PPO criteria, following criteria shall govern participation in the Program's Exclusive Provider Organization (EPO).

1. Hospital Participation

a. In each regional service area established by the Program, at least one tertiary care hospital facility shall be selected for participation.

b. To be eligible for selection as a tertiary care hospital facility, the hospital shall provide the following services:

i. general medical and surgical facilities (inpatient and outpatient);

ii. intensive and critical care units;

iii. emergency care facility;

iv. cardiovascular care unit;

v. obstetrical care, unless the Program contracts directly with an obstetrical care hospital facility in the region;

vi. rehabilitation; and

vii. skilled nursing unit.

c. Selection will be based upon cost analysis (60 percent) and market acceptability for plan participants (40 percent).

d. The hospital shall agree to participate for a minimum term of one year, consistent with the Program's plan year.

e. Selected hospitals shall execute an EPO hospital contract setting forth the Program's terms and conditions.

2. Physician Network Participation

a. In each regional service area established by the Program, at least one physician network shall be selected for participation.

b. To be eligible for selection, a physician network shall have at least 20 primary care physicians for each proposed region. Primary care physicians are licensed medical doctors practicing in the areas of family practice, general practice, internal medicine, pediatrics, and obstetrics/gynecology. A minimum of four physicians must practice in each of the following categories:

i. Family Practice, General Practice, or Internal Medicine;

ii. Pediatrics; and

iii. Obstetrics/Gynecology.

c. In addition to the primary care physician requirements, the physicians network in each proposed region shall include physicians practicing in the areas of Urology, General Surgery, Orthopedics, Radiology, Pathology, Anesthesiology, Otolaryngology, Neurology, Allergy, Gastroenterology, Ophthalmology and Dermatology. The Program may relax or enlarge this requirement based upon its contracting experience with a particular specialty.

d. A primary care physician may not participate in more than one EPO network in each region.

e. All physicians in the network shall participate for a minimum term of one year, consistent with the Program's plan year, except for reasons of retirement from the practice of medicine or relocation of the physician's practice out of the region.

f. Selection will be based upon cost analysis (60 percent) and market acceptability for plan participants (40 percent).

g. Selected physician networks shall execute an EPO physician contract setting forth the Program's terms and conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:25:859 (May 1999).

Chapter 11. Contributions

§1101. Collection and Deposit of Contributions

A. The board shall be responsible for preparing and transmitting to each participating employer a monthly invoice premium statement delineating the enrolled employees of that agency, the class of coverage, total amount of employer and employees contributions due to the board, and such other items as are deemed necessary by the board.

B. It shall be the responsibility of the participating employer to reconcile the monthly invoice premium statement, collect employee contribution by payroll deduction or otherwise, and remit the reconciled monthly invoice premium statement and both the employer and employee contributions to the board within 30 days after receipt of the monthly premium invoice statement.

C. Payments received by the board shall be allocated as follows:

1. first, to any late payment penalty due by the participating employer;
2. second, to any balance due from prior invoices; and
3. third, to the amount due under the current invoice.

D. All employer and employee premium contributions for the payment of premiums for group benefits for state employees provided under the board's authority shall be deposited directly with the board. The board shall pay all monies due for such benefits as they become due and payable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 8:285 (June 1982), amended LR 28:306 (February 2002).

§1103. Adjustments for Terminated Employees

A. Credit adjustments for premiums paid on behalf of employees and dependents of such employees whose coverage under the State Employees Group Benefits Program is terminated by reason of termination of employment with the participating employer may not be made by the participating employer after reconciliation of the second invoice following the date of termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002).

§1105. Penalty for Late Payment of Premiums

A. If any participating employer fails to remit, in full, both the employer and employee contributions to the board within 30 days after receipt of the monthly invoice premium statement, then:

1. at the request of the board, the state treasurer shall withhold from state funds due the participating employer the full amount of the delinquent employer and employee contributions and remit this amount directly to the board; and
2. the participating employer shall pay a penalty equal to 1 percent of the total amount due and unpaid, compounded monthly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002).

§1107. State Contribution toward Retirees' Health Premiums

A. For any person who is an active employee, as defined by R.S. 42:808 or OGB Rule, and who does not participate in an OGB Health Plan, as defined herein, before January 1, 2002, but subsequently enrolls in an OGB Health Plan, or any person who commences employment with an OGB participant employer on or after January 1, 2002, the state contribution of the premium for participation in an OGB Health Plan upon retirement shall be:

1. nineteen percent for those persons with less than ten years of participation in an OGB health plan before retirement;
2. thirty-eight percent for those persons with 10 years of participation but less than 15 years of participation in an OGB health plan before retirement;
3. fifty-six percent for those persons with 15 years of participation but less than 20 years of participation in an OGB health plan before retirement;
4. seventy-five percent for those persons with 20 or more years of participation in an OGB health plan before retirement.

B. The foregoing schedule will also apply to the state contribution toward premiums for surviving spouse and/or surviving dependent coverage for survivors of employees who retire on or after January 1, 2002 if such spouse and dependents are not enrolled in an OGB health plan before July 1, 2002.

C. This Rule does not affect the contributions paid by the state for:

1. any participant who is a covered retiree before January 1, 2002;
2. any active employee who is enrolled in an OGB Health Plan before January 1, 2002 and maintains continuous coverage through retirement;

3. surviving spouse and/or surviving dependent coverage for survivors of employees who retire on or after January 1, 2002 if such spouse and dependents are enrolled in an OGB health plan before July 1, 2002 and continuous coverage is maintained until the employee's death.

D. The term "OGB Health Plan" as used herein includes all health plans offered as primary health care plans to employees of OGB participating employers, for which the state contributes a share of the premium, including self-insured plans such as the PPO and the EPO, and fully insured HMO plans offered as alternative options.

E. For the purpose of determining the percentage of the state contribution toward premiums in accordance with this Rule, the number of years of participation in OGB Health Plans must be certified by the participating employer from which the employee retires on a form provided by OGB.

1. Such certification must be based upon business records maintained by the participating employer or provided by the employee.

2. Business records upon which certification is based must be available to OGB, the Division of Administration, and to the Legislative Auditor.

3. Not more than 120 days prior an employee's scheduled date of retirement, OGB will provide to the participating employer, upon request, all information in its possession relating to an employee's participation.

4. At the time of application for surviving spouse and/or surviving dependent coverage, OGB will provide, upon request, all information in its possession relating to participation of such surviving spouse and/or surviving dependent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002).

§1109. Retirees with Medicare

A. For all employees who retire on or after July 1, 1997, the reduced premium rate for retirees with Medicare will be applied only with respect to those persons who are enrolled for Medicare parts A and B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 98:496 (March 1998).

Chapter 13. Cost Assessment and Allocation

§1301. Cost Assessment and Allocation for FY 95/96

A. In accordance with the applicable provisions of R.S. 49:950 et seq., the Administrative Procedure Act, and R.S. 42:871(C) and 874(A)(2), vesting the Board of Trustees with the sole responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, and pursuant to the authority granted by R.S. 42:874(A)(10)(b), notice is hereby given that the Board of Trustees has adopted the following cost assessment and allocation:

B. Costs of \$24,634,446 for the fiscal year July 1, 1995 - June 30, 1996 are assessed to all employee/retiree members of the State Employees Group Benefits Program who are enrolled for health coverage under the comprehensive medical indemnity plan of the state or in a health maintenance organization with which the Board of Trustees has contracted, such costs to be allocated on a prorata basis in accordance with the classification of coverage for which the employees/retiree members are enrolled.

C. A complete list showing the amount of the allocation for each employee/retiree member in each class of coverage is available from the offices of the State Employees Group Benefits Program, 5825 Florida Boulevard, Baton Rouge, LA 70804.

D. The assessment is to be collected in the same manner as premiums for health coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 25:591 (June 1995).

Title 32 EMPLOYEE BENEFITS

Part III. Preferred Provider Organization (PPO)C Plan of Benefits

Chapter 1. Eligibility

§101. Persons to be Covered

Note: Eligibility requirements apply to all participants in the program, whether in the *PPO plan*, the *EPO plan* or an *HMO plan*.

A. Employee Coverage

1. *Employee*Csee §601.

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 at a later date to be covered separately, 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 the benefits.

3. Effective Dates of Coverage, New *Employee*. Coverage for each *employee* who completes the applicable *enrollment form* and agrees to make the required payroll contributions to his *participant employer* is to be effective as follows.

a. If employment begins on the first day of the month, coverage is effective the first day of the following month.

b. If employment begins on the second day of the month or after, coverage is effective the first day of the second month following employment.

c. *Employee Coverage* will not become effective unless the *employee* completes an application for coverage within 30 days following the date of employment. An *employee* who completes an application after 30 days following the date of employment will be considered an overdue applicant.

4. Employee Deferral Rule

a. If an *employee* is confined at home, in a *hospital*, nursing home, or elsewhere, by reason of disease, illness, accident, or injury on the date the *employee* would otherwise have become covered under this *plan*, the effective date of the *employee* and *dependent coverage* will be deferred until the date the *employee* returns to work for one full day.

b. The return to active work requirement will not serve to defer an *employee's* effective date of coverage in the event that the *employee's* normal place of employment is not open on the day he would otherwise have returned to work. If an *employee* is on an approved leave of absence on the day he would normally have returned to work, coverage will become effective on the day he returns to work.

5. Re-Enrollment, Previous Employment

a. An *employee* whose employment terminated while covered, who is re-employed within 12 months of the date of termination will be considered a re-enrollment, previous employment applicant. A re-enrollment previous employment applicant will be eligible for only that classification of coverage (*employee*, *employee* and one *dependent*, *family*) in force on the effective date of termination.

b. If an *employee* acquires an additional *dependent* during the period of termination, that *dependent* may be covered if added within 30 days of re-employment.

6. 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 Section does not apply to members of school boards or members of state boards or commissions who are defined by the *participant employer* as full time *employees*.

7. Legislative Assistants. Legislative assistants are eligible to participate in the *plan* if they are declared to be full-time *employees* by the *participant employer* and have at least one year of experience or receive at least 80 percent of their total compensation as legislative assistants.

8. Pre-Existing Condition (PEC)CNew *Employees* (on and after July 1, 2001)

a. The terms of the following paragraphs apply to all eligible *employees* whose employment with a *participant employer* commences on or after July 1, 2001, and to the *dependents* of such *employees*.

b. The *program* may require that such applicants complete a "Statement of Physical Condition" and an "Acknowledgement of Pre-Existing Condition" form.

c. Medical expenses incurred during the first 12 months that coverage for the *employee* and/or *dependent* is in force under the *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 effective date of coverage. The provisions of this Section do not apply to pregnancy.

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 of 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.

EMPLOYEE BENEFITS

B. *Retiree Coverage*

1. Eligibility. *Retirees* of *participant employers* are eligible for *retiree coverage* under this *plan*.

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. *Retirees* will not be eligible for coverage as overdue applicants.

b. A *retiree* retired from one *participant employer* may be covered as an *employee* of another *participant employer* or as a *retiree* of the *participant employer* from which he retired, but not both. In order to retain eligibility, upon termination of employment from the later *participant employer*, the *retiree* must return to the retirement group of his original *participant employer* within 30 days.

c. The *retiree* is responsible for notifying his initial *participant employer* of re-employment and return to *retiree* status.

C. *Dependent Coverage*

1. Eligibility. A *dependent* of an eligible *employee* or *retiree* will be eligible for *dependent coverage* on the later 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 for *dependents* 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*, if application is made within 30 days of the date of eligibility.

c. *Dependent Deferral Rule*. If a *dependent*, other than a newborn child or legal spouse of an *employee* is confined at home, in a nursing home, *hospital*, or elsewhere by reason of disease, illness, accident, or injury on the date he would otherwise become covered under this *plan*, the effective date of that *dependent's* coverage will be deferred until the date confinement terminates or *disability* ends, whichever is later.

D. Pre-Existing Condition (PEC)C 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 provisions of this Section do not apply to military reservists or national guardsmen ordered to active duty who return to state service and reapply for coverage with the *program* within 30 days of the date of reemployment. Coverage will be reinstated effective on the date of return to state service. The effective date of coverage will be:

a. the first day of the month following the date of receipt by the *program* of all required forms prior to the fifteenth of the month;

b. the first day of the second month following the date of the receipt by the *program* of all required forms on or after the fifteenth of the month.

2. The *program* will require that all overdue applicants complete a "Statement of Physical Condition" and an "Acknowledgement of Pre-existing Condition" form.

3. Medical expenses incurred during the first 12 months that coverage for the *employee* and/or *dependent* is in force under the *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 6-month period immediately prior to the effective date of coverage. The provisions of this Section do not apply to pregnancy.

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 without a break of 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 EnrollmentsC*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 has 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* 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 Acquiring *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 the termination date of the prior coverage or the date the new *dependent* is acquired. Persons eligible for special enrollment for which an application is made more than 30 days after eligibility will be considered overdue applicants subject to a pre-existing condition limitation.

b. The effective date of coverage shall be:

i. for loss of other coverage or marriage, the first day of the month following the date of receipt by the *program* of all required forms for enrollment;

ii. for birth of a *dependent*, the date of birth;

iii. for adoption, the date of adoption or placement for adoption.

c. Special enrollment applicants must complete an "Acknowledgment of Pre-existing Condition" and "Statement of Physical 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 6-month period immediately prior to the enrollment date. The provisions of this Section do not apply to pregnancy.

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 a coverage effective date of July 1. Transfer of coverage from the *plan* to the HMO or vice-versa will only be allowed during this annual enrollment period. Transfer of coverage will also be allowed as a consequence 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. If a *covered person* has elected to transfer coverage, but is hospitalized on July 1, the *plan*, which is providing coverage prior to July 1, will continue to provide coverage up to the date of discharge from the *hospital*.

H. *Medicare* Risk HMO Option for *Retirees*. *Retirees* who are eligible to participate in a *Medicare* Risk HMO plan who cancel coverage with the *program* upon enrollment in a *Medicare* Risk HMO plan may re-enroll in the *program* upon withdrawal from or termination of coverage in the *Medicare* Risk HMO 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1825 (October 1999), amended LR 27:721 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:2343 (November 2002).

§103. Continued Coverage

A. Leave of Absence. If an *employee* is allowed an approved leave of absence by his *participant employer*, he may retain his coverage for up to one year, if the premium is paid. Failure to do so will result in cancellation of coverage. 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 as of the effective date of withdrawal.

C. *Surviving Dependents/Spouse*. The provisions of this Section are applicable to surviving *dependents* who elect to continue coverage following the death of an *employee* or *retiree*. On or after July 1, 1999, eligibility ceases for a *covered person* who becomes eligible for coverage in a *group health plan* other than *Medicare*. Coverage under the *group health plan* may be subject to *HIPAA*.

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 until the surviving spouse becomes eligible for coverage in a *group health plan* other than *Medicare*.

b. The surviving *children* of an *employee* or *retiree* may continue coverage until they are 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/spouse* will be entitled to receive the same *participant employer* premium contributions as *employees* and *retirees*.

d. Coverage provided by the civilian health and medical *program* of the uniform services 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 events occurs:

i. failure to pay the applicable premium;

ii. death of the surviving spouse;

iii. on or after July 1, 1999, becomes eligible for coverage 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;

ii. on or after July 1, 1999, becomes eligible for coverage under any *group health plan* other than *Medicare*;

iii. the attainment of the termination age for *children*.

D. *Over-Age Dependents*. If an unmarried, never married *dependent* child is incapable of self-sustaining employment by reason of mental retardation or physical incapacity and became incapable prior to the termination age for *children* and is dependent upon the covered *employee* for support, the coverage for the *dependent* child may be continued for the duration of incapacity.

1. Prior to attainment of age 21 the *program* must receive documentation for *dependents* who are mentally retarded or who have a physical incapacity.

2. For purposes of this Section, mental illness does not constitute mental retardation.

3. The *program* may require that the covered *employee* submit current proof from a licensed medical doctor of continued mental retardation or physical incapacity as often as it may deem necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1827 (October 1999).

§105. COBRA

A. Employees

1. Benefits 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, 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 at the *employee's* own expense. *Employees* terminated for gross misconduct are not eligible for *COBRA*.

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. Application for continued coverage must be made in writing to the *program*

within 60 days of the date of notification and premium payment must be made within 45 days of the date the *employee* elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. Coverage under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium;
- b. 18 months from the date coverage would have terminated;
- c. entitlement to *Medicare*;
- d. coverage under a *group health plan*, except when subject to a pre-existing condition limitation.

B. Surviving Dependents

1. Benefits 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 notification. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated.

a. Coverage for the surviving *dependents* under this Section will continue until the earliest of the following:

- i. failure to pay the applicable premium;
- ii. death of the surviving spouse;
- iii. entitlement to *Medicare*;
- iv. coverage under a *group health plan*, except when subject to a pre-existing condition limitation.

b. Coverage for a surviving *dependent* child under this Section will continue until the earliest of the following:

- i. failure to pay the applicable premium;
- ii. 36 months beyond the date coverage would have terminated;
- iii. entitlement to *Medicare*;
- iv. coverage under a *group health plan*, except when subject to a pre-existing condition.

C. Divorced Spouse

1. Coverage under this *plan* 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. 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 notification. Premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have terminated.

2. Coverage for the divorced spouse under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium;
- b. 36 months beyond the date coverage would have terminated;
- c. entitlement to *Medicare*;
- d. coverage under a *group health plan*, except when subject to a pre-existing condition.

D. Dependent Children

1. Benefits 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. 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.

2. 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 the continued coverage is elected, for coverage retroactive to the date coverage would have terminated.

3. Coverage for *children* under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium;
- b. 36 months beyond the date coverage would have terminated;
- c. entitlement to *Medicare*;
- d. coverage under a *group health plan*, except when subject to a pre-existing condition.

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*.

2. Then, the spouse and/or *dependent* child may elect to continue coverage at their own expense. Coverage will not be continued beyond 36 months from the date coverage would have terminated.

EMPLOYEE BENEFITS

F. *Dependents* of Non-Participating Terminated Employee

1. If an *employee* no longer meets the definition of an *employee*, or a 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 their own expense. The elected coverage will be subject to the notification and termination provisions.

2. In the event a *dependent* child, covered under the provisions of the preceding paragraph no longer meets the definition of an eligible covered *dependent*, he or she may elect to continue coverage at his or her own expense. Coverage cannot be continued beyond 36 months from the date coverage would have terminated.

G. 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 *employee* and *retirees*.

H. *Disability COBRA*

1. If a covered *employee* or covered *dependent* is determined by social security or by the *program* staff (in the case of a person who is ineligible for social security *disability* 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 terminated. To qualify the *covered person* must:

a. submit a copy of his or her social security *disability* determination to the *program* before the initial 18-month continued coverage period expires and within 60 days after the date of issuance of the social security determination; or

b. submit proof of total *disability* to the *program* before the initial 18-month continued coverage period expires.

2. 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.

3. The staff and medical director of the *program* will make this 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.

4. Coverage under this Section will continue until the earliest of the following:

a. 30 days after the month in which social security 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 social security);

b. 29 months from the date coverage would have terminated.

I. *Medicare COBRA*. If an *employee* becomes entitled to *Medicare* on or 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 be the earliest of the following:

1. failure to pay the applicable premium;

2. 36 months beyond the date coverage would have terminated;

3. entitlement to *Medicare*;

4. coverage under a *group health plan*, except when subject to a pre-existing condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1828 (October 1999).

§107. **Change of Classification**

A. Adding or Deleting *Dependents*. The *plan member* must notify the *program* whenever a *dependent* is added to, or deleted from, the *plan member's* coverage, regardless of whether the addition or deletion would result 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, by reason of a change in family status (e.g., marriage, birth of child), the class of coverage is subject to change, effective on the date of the event, if application for the change is made within 30 days of the date of the event.

2. When the addition of a *dependent* results in the class of coverage being changed, the additional premium will be charged for the entire month if the date of change occurs on or before the fourteenth day of the month. If the date of change occurs on or after the fifteenth day of the month, additional premium will not be charged until the first day of the following month.

C. Notification of Change. It is the responsibility of the *employee* to notify the *program* of any change in classification of coverage affecting the *employee's* contribution amount. Any such failure later determined will be corrected on the first day of the following month.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1829 (October 1999).

§109. Contributions

A. The state of Louisiana may make a contribution toward the cost of the *plan*, as determined on an annual basis by the legislature.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999).

Chapter 2. Termination of Coverage**§201. Active Employee and Retired Employee Coverage**

A. Subject to continuation of coverage and *COBRA* rules, all benefits of a *covered person* will terminate under these *plan* on the earliest of the following dates:

1. on the date the *program* terminates;
2. on the date the group or agency employing the covered *employee* terminates or withdraws from the *program*;
3. on the contribution due date if the group or agency fails to pay the required contribution for the covered *employee*;
4. on the contribution due date if the *covered person* fails to make any contribution which is required for the continuation of his coverage;
5. on the last day of the month of the covered *employee's* death;
6. on the last day of the month in which the covered *employee* ceases to be eligible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999).

§203. 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. on the last day of the month the *employee* ceases to be covered;
2. on 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, on 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*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999).

Chapter 3. Medical Benefits**§301. Medical Benefits Apply When Eligible Expenses Are Incurred by a Covered Person**

A. Eligible Expenses. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable *deductibles*, limits of the *fee schedule*, schedule of benefits, exclusions and other provisions of the *plan*. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. *hospital* care. The medical services and supplies furnished by a *hospital* or ambulatory surgical center. Covered charges for *room and board* will be payable as shown in the schedule of benefits;
2. 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;
5. laboratory examinations and diagnostic X-rays;
6. nuclear medicine and electroshock therapy;
7. blood and blood plasma, blood derivatives and blood processing, when not replaced;
8. surgical and medical supplies billed for *treatment* received in a *hospital* or ambulatory surgical center, and other covered provider's surgical and medical supplies as listed below:
 - a. cathetersC external and internal;
 - b. cervical collar;
 - c. leg bags for urinal drainage;
 - d. ostomy supplies;
 - 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 licensed physical, occupational or speech therapist when prescribed by a *physician* and pre-approved through outpatient certification procedure;
10. intravenous injections, solutions, and eligible related intravenous supplies;

EMPLOYEE BENEFITS

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; and

c. coverage remains continuously in effect with respect to the *covered person* during the course of the *treatment*; eligible expenses will be limited to the original estimated total cost of *treatment* as estimated at the time of initial *treatment*;

12. *durable medical equipment*, subject to the lifetime maximum payment limitation as listed in the schedule of benefits. The *program* will require written certification by the treating *physician* to substantiate the medical necessity for the equipment and the length of time it will be used;

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, 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. The *program* will consider a maximum up to \$350 less a \$50 copayment for transportation charges. Medical services and supplies will be considered separately;

b. licensed air ambulance service to a *hospital* with facilities to treat an illness or injury. The *program* will consider a maximum up to \$1,500 less a \$250 copayment. Medical services and supplies will be considered separately;

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;

19. acupuncture when rendered by a medical doctor;

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 by the state in which the services are rendered when prescribed by a licensed medical doctor:

a. services require the skills of and performed by a licensed physical therapist or licensed occupational therapist;

b. restorative potential exists;

c. meets the standard for medical practice;

d. reasonable and necessary for the *treatment* of the disease, illness, accident, injury or postoperative condition;

e. approved through outpatient procedure certification;

22. *cardiac rehabilitation* when:

a. rendered at a medical facility under the supervision of a *physician*;

b. rendered in connection with a myocardial infarction, angioplasty with or without stenting, or cardiac bypass surgery;

c. completed within 6 months following the qualifying event;

NOTE: Charges incurred for dietary instruction, educational services, behavior modification literature, health club membership, exercise equipment, preventative programs, and any other items excluded by the *plan* are not covered.

23. routine physical examinations and immunizations as follows:

a. *well-baby care* expenses subject to the annual *deductible* and co-payments:

i. newborn facility and professional charges;

ii. birth to age 1C all office visits for scheduled immunizations and screening;

b. *well-child care* expenses subject to the annual *deductible* and co-payments:

i. age 1 to age 3C3 office visits per year for scheduled immunizations and screening;

ii. age 3 to age 16C1 office visit per year for scheduled immunizations and screening;

c. *well-adult care* expenses not subject to the annual *deductible*, but limited to a maximum benefit of \$200:

- i. age 16 to age 40C1 physical every 3 years;
 - ii. age 40 to age 50C1 physical every 2 years;
 - iii. age 50 and overC1 physical every year;
24. not subject to the annual *deductible*:
- a. one pap test for cervical cancer per *calendar year*;
 - b. screening mammographic examinations performed according to the following schedule:
 - i. one baseline mammogram during the five-year period a person is 35-39 years of age;
 - ii. one mammogram every two *calendar years* for any person who is 40-49 years of age or more frequently if recommended by a *physician*;
 - 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 twelve months for men over the age of 50 years, and as *medically necessary* for men over the age of 40 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. physician's assistants, perfusionists, and registered nurse assistants assisting in the operating room;
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, such benefits not to exceed \$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.a. testing of sleep disorders only when the tests are performed at either:

- i. a sleep study facility accredited by the American Sleep Disorders Association or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

- ii. a sleep study facility located within a healthcare facility accredited by JCAHO.

b. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:480 (March 2002).

§303. Fee Schedule

A. The *fee schedule* sets the maximum fee that the *program* will allow for an eligible medical expense.

B. If the medical provider accepts an assignment of benefits, the *plan member* cannot be billed for amounts exceeding the *fee schedule*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999).

§305. Automated Claims Adjusting

A. Auto Audit is a 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 reduced amounts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999).

§307. Utilization ReviewCPre-Admission Certification, Continued Stay Review

A. Pre-Admission Certification (PAC) and continued stay review (CSR) establish the medical necessity and length of inpatient *hospital* confinement.

EMPLOYEE BENEFITS

1. It is the *plan member's* responsibility to assure that PAC is obtained 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 2 days or less. If the mother's stay exceeds or is expected to exceed 2 days, PAC is required within 24 hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate precertification number must be obtained for the baby. In the case of a scheduled caesarean section, it is required that PAC be obtained prior to or the day of admission.

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 48 hours of 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 percent on any confinement for which PAC was not obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999).

§309. Outpatient Procedure Certification (OPC)

A. OPC certifies that certain outpatient procedures and therapies are *medically necessary*.

1. It is the *plan member's* responsibility to assure that OPC is obtained on services performed by non-*PPO* providers.

2. On services performed by a *PPO* provider, it is the provider's responsibility to obtain OPC. The *plan member* cannot be billed if the provider fails to do so.

B. OPC is required on the following procedures:

1. cataract;
2. laparoscopic cholecystectomy;
3. lithotripsy;
4. magnetic resonance imaging:
 - a. brain/head lower extremity;
 - b. upper extremity;
 - c. spine;

5. knee arthroscopy;

6. septoplasty;

7. therapies:

- a. *physical therapy*;
- b. speech therapy;
- c. *occupational therapy*;
- d. therapy with unlisted modality.

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

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.

D. Benefits otherwise payable for services rendered by a non-*PPO* provider will be reduced by 25 percent for any procedure or therapy on which OPC was not obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999).

§311. 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 that are not normally covered. To be eligible, the condition being treated must be a covered condition, and case management must be approved prior to the service being rendered.

C. These charges are subject to the *deductible*, co-insurance, *fee schedule* and maximum benefit limitations.

D. The following criteria must be met:

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. If approved, case management may provide any of the following:

1. alternative care in special *rehabilitation* facilities;
2. alternative care in a skilled nursing facility/unit or swing bed (not nursing home), or the patient's home, subject to the *deductible* and coinsurance;
3. avoidance of complications by earlier *hospital* discharge, alternative care and training of the patient and/or family;
4. home health care services limited to 150 visits per *plan* year;
5. hospice care;
 - a. not subject to the *deductible*;
 - b. benefits are always payable at 80 percent, never at 100 percent.
6. private duty nursing care;
7. total parenteral nutrition provided that home visits for TPN are not reimbursable separately;
8. enteral nutrition up to a single 90-day period for instances where through surgery or neuromuscular mechanisms, the patient cannot maintain nutrition and the condition can reasonably be expected to improve during this one 90-day timespan.

F. Mental health and substance abuse *treatments* or conditions are not eligible for case management.

G. 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.

H. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999).

§313. 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. Expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care are subject to the *deductible*, co-insurance and the maximum benefit provisions of the *plan*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999).

§315. Medicare Reduction

A. If the patient has not chosen and paid a separate premium for the full coordination of benefits option, the charges will be reduced by whatever amounts are paid or payable by *Medicare*. The *program* requires written confirmation from the Social Security Administration or its successor if a person is not eligible for *Medicare* coverage. All provisions of this *plan*, including all limitations and exceptions, will be applied.

B. *Retiree* 100-*Medicare* COB. Upon enrollment and payment of the additional monthly premium, a *plan member* and his *dependents* may choose to have full coordination of benefits with *Medicare*. Enrollment must be made within 30 days of eligibility for *Medicare* or within 30 days of retirement if already eligible for *Medicare* and at the annual open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999).

§317. Exceptions and Exclusions for All Medical Benefits

A. No benefits are provided under this *plan* for:

1. cases covered, in whole or in part, by 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. convalescent, skilled nursing, sanitarium, or *custodial care* or *rest cure*;
3. expenses for elective, non-therapeutic voluntary abortion, although expenses for complications as a result are covered;
4. injuries sustained while in an aggressor role;
5. expenses incurred as a result of the patient's attempt at a felony or misdemeanor;
6. expenses incurred by a *covered person* in connection with cosmetic surgery, unless necessary for the immediate repair of a deformity caused by a disease and/or injury which 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. expenses incurred for shoes and related items similar to wedges, cookies and arch supports;
8. any expense, except for actual out-of-pocket expenses, incurred by a member of a *Health Maintenance Organization* (HMO), *Health Maintenance Plan* (HMP) or other prepaid medical plan or medical services plan if the *covered person* is enrolled on a group (employer-sponsored) basis;

EMPLOYEE BENEFITS

9. dental braces and orthodontic appliances (for whatever reason prescribed or utilized) and *treatment* of periodontal disease;
10. dentures, dental implants and any surgery for their use, except if needed as the result of an accident that meets the *program's* requirements;
11. medical services, *treatment* or prescription drugs provided without charge to the *covered person* or for which the *covered person* is not legally obligated to pay;
12. maternity expenses incurred by any person other than the *employee* or the *employee's* legal spouse;
13. personal convenience items including, but not limited to, admit kits, bedside kits, telephone and television, guest meals, beds, and similar items;
14. charges for services and supplies 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*;
15. services and supplies which are not *medically necessary*;
16. services rendered for remedial reading and recreational, visual and behavioral modification therapy, *pain rehabilitation control and/or therapy*, and dietary or educational instruction for all illnesses, other than diabetes;
17. services and supplies in connection with or related to gender dysphoria or reverse sterilization;
18. artificial organ implants, penile implants, transplantation of other than homo sapiens (human) organs;
19. expenses after the initial diagnosis, for infertility and complications, including, but not limited to, services, drugs, and 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;
20. 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, and any other items not normally considered medical supplies;
21. administrative fees, interest, penalties or sales tax;
22. marriage counseling and/or family relations counseling;
23. charges for services rendered over the telephone from a *physician* to a *covered person*;
24. radial keratotomy or any procedures for the correction of refractive errors;
25. speech therapy, except when ordered by a *physician* 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;
26. services and supplies related to obesity, surgery for excess fat in any area of the body, resection of excess skin or fat following weight loss or pregnancy;
27. hearing aids, or any examination to determine the fitting or necessity;
28. hair transplants;
29. routine physical examinations or immunizations not listed under eligible expenses;
30. diagnostic or *treatment* measures which are not recognized as generally accepted medical practice;
31. medical supplies not listed under eligible expenses;
32. *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;
33. expenses for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, dental procedures which fall under the guidelines of eligible dental accidents, 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;
34. genetic testing, except when determined to be *medically necessary* during a covered pregnancy;
35. *Treatment* for temporomandibular joint dysfunction (TMJ), except as listed under eligible expenses;
36. services of a private-duty registered nurse (R.N.) or of a private-duty licensed practical nurse (L.P.N.);
37. breast thermograms;
38. services rendered by any provider related to the patient by blood, adoption or marriage;
39. expenses from a provider who is not licensed in the state where services are rendered;
40. facility fees for services rendered in a *physician's* office or in any facility not approved by the federal Health Care Financing Administration for payment of such fees under *Medicare*;
41. glucometers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1834 (October 1999), amended LR 26:488 (March 2000), LR 27:720 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:2343 (November 2002).

§319. Coordination of Benefits

A. Coordination of benefits is the order of payment when two or more plans are involved. When a patient is also covered by another plan, the plans will coordinate benefits.

B. 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, except for *Health Maintenance Organizations* or other types of employer-sponsored prepaid medical plans.

b. The plan that pays first will pay as if there were no other plan involved. The secondary and subsequent plans may pay the balance due up to 100 percent of the total allowable expense. No plan will pay benefits greater than it would have paid in the absence of coordination of benefits.

D. *Health Maintenance Organizations* (HMO). If a person is also covered as a *dependent* under a *Health Maintenance Organization* (HMO), the *program* will consider the HMO as the primary carrier. The *plan* will consider as eligible only those actual out-of-pocket expenses incurred that the patient is legally obligated to pay.

E. Preferred Provider Organizations (*PPO*). In the event that a *covered person* is also covered as a *dependent* under a *PPO* contract, the *plan* will consider as eligible only those expenses actually incurred by the *covered person* under the terms of the *PPO* contract, and for which the *covered person* is legally obligated to pay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1835 (October 1999).

§321. Preferred Provider Program

A. The *program* may implement Preferred Provider Organization (*PPO*) arrangements or other agreements to discount payable fees. The *program* reserves to itself the right to negotiate the amount of the discount, the incentives to be 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 would be on 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.

1. 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 percent of the first \$10,000 of eligible expenses and 100 percent of eligible expenses, except prescription drugs, in excess of \$10,000 for the remainder of the *calendar year* subject to the maximum amount as specified in the schedule of benefits.

2. Point of Service *PPO* Regions (Areas)

a. The following regions are used to determine whether there is a *PPO* provider in the same area as the point of service:

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

b. If a non-*PPO* provider is used in an area where there are *PPO* providers of the same service, then the *plan member* is reimbursed 50 percent of the eligible expenses. If there is no *PPO* provider of the same service in the area where the service is provided, then the *plan member* is reimbursed 80 percent of eligible expenses. If services are received from a *PPO*, then services are reimbursed at 90 percent of the *PPO* rate with payments made to the *PPO* provider. These are all made subject to *deductibles* to the *PPO* provider. There is contractual assignment to every *PPO* provider.

c. A non-*PPO hospital* will be paid, after applicable *deductibles*, 80 percent of eligible expenses for *emergency room services* provided at the *hospital* emergency room and billed by that *hospital*. The *plan member* has the responsibility for establishing that the *treatment services* were *emergency room services*, as defined by the *program*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1835 (October 1999), amended LR 27:722 (May 2001).

§323. Prescription Drug Benefits

A. This *plan* allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor requiring a prescription and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a *covered person* as an inpatient *hospital* patient or an outpatient *hospital* patient, including insulin, Retin-A dispensed for *covered persons* under the age of 26, vitamin B12 injections, prescription potassium chloride, and over-the-counter diabetic supplies including, but not limited to, strips, lancets, and swabs. In addition, this *plan* allows benefits, not to exceed \$200 per month, for

EMPLOYEE BENEFITS

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.

1. *Inherited Metabolic Disease*Ca disease caused by an inherited abnormality of body chemistry and shall be limited to:

- a. phenylketonuria (PKU);
- b. maple syrup urine disease (MSUD);
- c. methylmalonic acidemia (MMA);
- d. isovaleric acidemia (IVA);
- e. propionic acidemia;
- f. glutaric acidemia;
- g. urea cycle defects;
- h. tyrosinemia.

2. *Low Protein Food Products*Ca food product that is especially formulated to have less than one gram of protein per serving and is 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 a natural food that is naturally low in protein.

B. The following drugs, medicines, and related services 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. 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;
7. nutritional or parenteral therapy;
8. vitamins and minerals;
9. drugs available over the counter; and
10. serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting;
11. drugs for *treatment* of impotence, except following surgical removal of the prostate gland; and
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* document, the following apply to expenses incurred for outpatient prescription drugs.

1. Upon presentation of the Group Benefits *Program* 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 a maximum of \$40 per prescription dispensed. The *plan* will pay the balance of the eligible expense for prescription drugs dispensed at a *network pharmacy*. There is a \$1000 per person per *calendar year* out-of-pocket threshold for eligible prescription drug expenses. Once this threshold is reached, that is, the *plan member* has paid \$1000 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*.

NOTE: For the period July 1, 2001 through December 31, 2001, the out-of-pocket threshold will be \$500 per person. On January 1, the threshold will be re-set to \$1000 for *calendar year* 2002 and each subsequent year.

2. In the event the *plan member* does not present the Group Benefits *Program* 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 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 34-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 102-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 1-34 days the *plan member* will be responsible for payment of 50 percent of the cost of the drug, up to a maximum of \$40 per prescription dispensed.

ii. For a supply of 35-64 days the *plan member* will be responsible for payment of fifty percent of the cost of the drug, up to a maximum of \$80 per prescription dispensed.

iii. For a supply of 69-102 days the *plan member* will be responsible for payment of 50 percent of the cost of the drug, up to a maximum of \$120 per prescription dispensed.

iv. Once the out-of-pocket threshold for eligible prescription drug expenses is reached, the *plan member's* co-payment responsibility will be \$15 for a 1-34 days supply, \$30 for a 35-64 days supply, and \$45 for a 69-102 days supply, with no co-pay for up to a 102-days supply of generic drugs.

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

7. *Generic Drug* a chemically equivalent copy of a brand drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1835 (October 1999), amended LR 27:720 (May 2001), LR 27:721 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1887 (November 2001), LR 28:2344 (November 2002).

Chapter 4. Uniform Provisions

§401. Statement of Contractual Agreement

A. This written *plan* document as amended and any documents executed by or on behalf of the covered *employee* constitute the entire agreement between the parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999).

§403. Properly Submitted Claim

A. For *plan reimbursements*, all bills must show:

1. *employee's* name;
2. name of patient;
3. name, address, and telephone number of the provider of care;
4. diagnosis;
5. type of services rendered, with diagnosis and/or procedure codes;
6. date of service;
7. charges;
8. *employee's* member number;
9. provider tax identification number;
10. *Medicare* explanation of benefits, if applicable.

B. The *program* can require additional documentation in order to determine the extent of coverage or the appropriate *reimbursement*. Failure to furnish the requested information will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999).

§405. 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 claims is submitted to a clearinghouse or to the providers practice management system.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002).

§407. Right to Receive and Release Information

A. The *program* may release to, or obtain from any company, organization, or person, without consent of or notice to any person, any information regarding any person which the *program* deems necessary to carry out the provisions of this *plan*, or like terms of any plan, or to determine how, or if, they apply. Any claimant under this *plan* must furnish to the *program* any information necessary to implement this provision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999).

§409. Legal Limitations

A. A *plan member* must exhaust the administrative claims review procedure 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 is required to be filed or more than thirty days after mailing of the notice of decision of the administrative claims *committee*, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002).

§411. Benefit Payments to Other Group Health Plans

A. When payments, which should have been made under this *plan*, have been made by another *group health plan*, the *program* may pay to the other plan the sum proper to satisfy the terms of this *plan* document.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999).

§413. Recovery of Overpayments

A. 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 percent of the overpayment or \$1,000 whichever is greater. The defendant will also be responsible for court costs and legal interest from date of judicial demand until paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999).

§415. Third Party Recovery Provision

A. Right of *Subrogation* and *Reimbursement*. When this provision applies, the *covered person* may incur medical or dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the *covered person* may have a claim against the third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this *plan* for those incurred medical or dental expenses automatically assigns to the *program* any rights the *covered person* may have to recover payments from any third party or insurer. This right allows the *program* to pursue any claim which the *covered person* has against any third party, or insurer, whether or not the *covered person* chooses to pursue that claim. The *program* may make a claim directly against the third party or insurer, but in any event, the *program* has a lien on any amount recovered by the *covered person* whether or not designated as payment for medical expenses. This lien will remain in effect until the *program* is repaid in full. The *program* reserves the right to recover either from the liable third party or the *covered person*. The *covered person*:

1. automatically assigns to the *program* his or her rights against any third party or insurer when this provision applies;

2. must notify the *program* of a pending third-party claim; and

3. must repay to the *program* the benefits paid on his or her behalf out of the *recovery* made from the third party or insurer.

B. Amount Subject to *Subrogation* or *Reimbursement*

1. The *covered person* agrees to recognize the *program's* right to *subrogation* and *reimbursement*. These rights provide the *program* with a priority over any funds paid by a third party to a *covered person* relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

2. Notwithstanding its priority to funds, the *program's subrogation* and *reimbursement* rights, as well as the rights assigned to it, are limited to the extent to which the *program* has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the *program*.

3. When a right of *recovery* exists, the *covered person* will cooperate and provide requested information as well as doing whatever else is needed to secure the *program's* right of *subrogation* and *reimbursement* as a condition to having the *program* make payments. In addition, the *covered person* will do nothing to prejudice the right of the *program* to subrogate or seek *reimbursement*.

4. This right of refund also applies when a *covered person* recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any liability plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999).

§417. Employer Responsibility

A. It is the responsibility of the *participant employer* to submit enrollment and change forms and all other necessary documentation on behalf of their *employees* to the *program*. *Employees* of a *participant employer* will not by virtue of furnishing any documentation to the *program* on behalf of a *plan member*, be considered agents of the *program*, and no representation made by any such person at any time will change the provisions of this *plan*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999).

§419. Program Responsibility

A. The *program* will administer the *plan* in accordance with the terms of the *plan* document, state and federal law, and its established policies, interpretations, practices, and procedures. It is the express intent of this *program* that the *board of trustees* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *plan*, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to *covered person's* rights, and to decide questions of *plan* document interpretation and those of fact relating to the *plan* document. The decisions of the *board of trustees* or its *committees* will be final and binding on all interested parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999).

§421. 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 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999).

§423. Plan Document and/or Contract Amendments or Termination

A. The *program* has the statutory responsibility of providing health and accident and death benefits for *covered persons* to the extent that funds are available. The *program* reserves to itself the right to terminate or amend the eligibility and benefit provisions of its *plan* document from time to time as it may deem necessary to prudently discharge its duties. Termination or 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 participant, whether active or retired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1838 (October 1999).

Chapter 5. Claims Review and Appeal

§501. Administrative Review

NOTE: This Section establishes and explains the procedures for review of benefit and eligibility decisions by the *program*.

A. Administrative Claims Review

1. The *covered person* may request from the *program* a review of any claim for benefits or eligibility. The written request must include the name of the *covered person*,

member number, the name of the patient, the name of the provider, dates of service and should clearly state the reasons for the *appeal*.

2. 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

1. 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 to recover benefits allegedly payable under the *program*.

C. Administrative Claims *Committee*

1. The *CEO* will appoint an administrative claims *committee* (the *committee*) to consider all such requests for review and to ascertain whether the initial determination was made in accordance with the *plan document*.

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. Upon completion of the review the *committee* will render its decision which will be based on the *plan document* and the information included in the record. The decision will contain a statement of reasons for the decision. A copy of the decision will be mailed to the *covered person* and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801.C and 802.B.(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1838 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002), LR 28:2344 (November 2002).

NOTE: Former §§501-513 redesignated herein as §501.A-D.

§503. Appeals from Medical Necessity Determinations

NOTE: The following provisions will govern appeals from adverse determinations based upon medical necessity by OGB's Utilization Review Organization (URO) pursuant to Article 3, Section IV of this document.

A. *First Level Appeal*. Within 60 days following the date of an adverse initial determination based upon medical necessity, the *covered person*, or the provider acting on behalf of the *covered person*, may request a first level *appeal*.

EMPLOYEE BENEFITS

1. Each such *appeal* will be reviewed within the URO by a health care professional who has appropriate expertise.

2. The URO will provide written notice of its decision.

B. Second Level Review. Within 30 days following the date of the notice of an adverse decision on a first level *appeal*, a *covered person* may request a second level review.

1. Each such second level review will be considered by a panel within the URO that includes health care professionals who have appropriate expertise and will be evaluated by a clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed.

a. The review panel will schedule and hold a review meeting, and written notice of the time and place of the review meeting will be given to the *covered person* at least 15 working days in advance.

b. The *covered person* may:

i. present his/her case to the review panel;

ii. submit supporting material and provide testimony in person or in writing or affidavit both before and at the review meeting; and

iii. ask questions of any representative of the URO.

c. If 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 written notice of its decision on the second level review.

C. External Review. Within 60 days after receipt of notice of a second level *appeal* adverse determination, the *covered person* whose medical care was the subject of such determination, with the concurrence of the treating health care provider, may submit request for an external review to the URO.

1. The URO will provide the 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.

4. An external review decision will be binding on the URO, on OGB and on the covered regarding the medical necessity determination.

D. Expedited Appeals

1. An expedited *appeal* may be initiated by the *covered person*, with the consent of the treating health care professional, or the 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. any request concerning an admission, availability of care, continued stay, or health care service for a *covered person* who has received emergency services but has not been discharged from a facility.

2. In an expedited *appeal* the URO will make a decision and notify the *covered person*, or the provider acting on behalf of the *covered person*, as expeditiously as the *covered person's* medical condition requires, but in no event more than 72 hours after the *appeal* is commenced.

3. The URO will provide written confirmation of its decision concerning an expedited *appeal* if the initial notification is not in writing.

4. In any case where the expedited *appeal* does not resolve a difference of opinion between the URO and the *covered person*, or the provider acting on behalf of the *covered person*, such provider may request a second level review of the adverse determination.

E. Expedited External Review of Urgent Care Requests

1. When the *covered person* receives an adverse determination involving an emergency medical condition of the *covered person* 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 will be binding on the URO, on OGB and on the covered regarding the medical necessity determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801.C and 802.B.(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1838 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002), LR 28:2344 (November 2002).

Chapter 6. Definitions

§601. Definitions

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

Benefit Payment—payment of eligible expenses incurred by a *covered person* during a *calendar year* at the rate shown under percentage payable in the schedule of benefits.

Board of Trustees—the entity created and empowered to administer the State Employees Group Benefits *Program*.

Calendar Year—that period commencing at 12:01 a.m., January 1, standard time, at the address of the *employee*, or the date the *covered person* first becomes covered under the *plan* and continuing until 12:01 a.m., standard time, at the address of the *employee* on the next following January 1. Each successive *calendar year* will be the period from 12:01 a.m., January 1, standard time, at the address of the *employee* to 12:01 a.m., the next following January 1.

CEO—the Chief Executive Officer of the *program*.

Children—

1. any natural or legally adopted *children* of the *employee* and/or the *employee's* legal spouse *dependent* upon the *employee* for support;

2. any *children* in the process of being adopted by the *employee* through an agency adoption who are living in the household of the *employee* and who are or will be included as a *dependent* of the *employee's* federal income tax return for the current or next tax year (if filing is required);

3. other *children* for whom the *employee* has legal custody, who live in the household of the *employee*, and who are or will be included as a *dependent* on the *employee's* federal income tax return for the current or next tax year (if filing is required);

4. grandchildren for whom the *employee* does not have legal custody, who are dependent upon the *employee* for support, and one of whose parents 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 *plan member*, execute an acknowledgement of paternity. If *dependent* parent becomes ineligible, the grandchild becomes ineligible for coverage, unless the *employee* has legal custody of the grandchild.

COBRAC—federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 with amendments.

Committee—the grievance *committee* of the board.

Covered Person—an active or retired *employee*, or his 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 being made.

Custodial Care—care designed essentially to assist an individual to meet his activities of daily living (i.e. services which constitute personal care such as help in walking, getting in and out of bed, assisting in bathing, dressing, feeding, using the toilet and care which does not require admission to the *hospital* or other institution for the *treatment* of a disease, illness, accident or injury, or for the performance of surgery; or care primarily to provide *room and board* with or without routine nursing care, training in personal hygiene and other forms of self-care) and supervisory care by a doctor for a person who is mentally or physically incapacitated and who is not under specific medical, surgical or psychiatric *treatment* to reduce the incapacity to the extent necessary to enable the patient to live outside an institution providing medical care, or when, despite *treatment*, there is not reasonable likelihood that the incapacity will be so reduced.

Date Acquired—the date a *dependent* of a covered *employee* is acquired in the following instance and on the following dates only:

1. legal spouse—date of marriage;

2. *children*:

a. natural *children*—the date of birth;

b. *children* in the process of being adopted:

i. agency adoption—the date the adoption contract was executed by the *employee* and the adoption agency;

ii. private adoption—the date of the execution of the act of voluntary surrender in favor of the *employee*, if the *program* is furnished with certification by the appropriate clerk of court setting forth the date of execution of the act and the date that said act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;

c. other *children* living in the household of the covered *employee* who are or will be included as a *dependent* on the *employee's* federal income tax return—the date of the court order granting legal custody;

d. grandchildren for whom the *employee* does not have legal custody, who are dependent upon the *employee* for support, and one of whose parents is a covered *dependent* as defined:

i. the date of birth, if all the requirements are met at the time of birth; or

ii. the date on which the coverage becomes effective for the covered *dependent*, if all the requirements are not met at the time of birth.

Deductible—the amount of covered charges for which no benefits will be paid. Before benefits can be paid in a *calendar year*, a *covered person* must meet the *deductible* shown in the schedule of benefits.

EMPLOYEE BENEFITS

Dependent Any of the following persons who are enrolled for coverage as *dependents*, if they are not also covered as an *employee*:

1. the covered *employee's* legal spouse;
2. any (never married) *children* from date of birth (must be added to coverage within 30 days from *date acquired* by completing appropriate enrollment documents) up to 21 years of age, dependent upon the *employee* for support;
3. any unmarried (never married) *children* 21 years of age, but under 24 years of age, who are enrolled and attending classes as full-time students and who depend upon the *employee* for support. The term full-time student means students who are enrolled at an accredited college or university, or at a vocational, technical, or vocational-technical or trade school or institute, or secondary school, for the number of hours or courses which is considered to be full-time attendance by the institution the student is attending;
 - a. it is the responsibility of the *plan member* to furnish proof acceptable to the *program* documenting the full-time student status of a *dependent* child for each semester;

4. any *dependent* parent of an *employee* or of an *employee's* legal spouse, if living in the same household, was enrolled prior to July 1, 1984, and who is, or will be, claimed as a *dependent* on the *employee's* federal income tax return in the current tax year. The *program* will require an affidavit stating the covered *employee* intends to include the parent as a *dependent* on his federal income tax return for the current tax year. Continuation of coverage will be contingent upon the payment of a separate premium for this coverage.

Dependent Coverage Cbenefits with respect to the *employee's dependents* only.

Disability Cthat the *covered person*, if an *employee*, is prevented, solely because of a disease, illness, accident or injury from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit; or, if a *dependent*, is prevented solely because of a disease, illness, accident or injury, from engaging in substantially all the normal activities of a person of like age in good health.

Durable Medical Equipment Cequipment which:

1. can withstand repeated use;
2. is primarily and customarily used to serve a medical purpose;
3. generally is not useful to a person in the absence of a illness or injury; and
4. is appropriate for use in the home. *Durable medical equipment* includes, but is not limited to, such items as wheelchairs, *hospital* beds, respirators, braces (non-dental) and other items that the *program* may determine to be *durable medical equipment*.

Emergency Room Services Chospital services eligible for *reimbursement*, provided at a *hospital* Emergency Room and billed by a *hospital*, and provided on an expeditious basis for *treatment* of unforeseen medical conditions which, if not immediately diagnosed and treated, could reasonably result in physical impairment or loss of life.

Employee Ca full-time *employee* as defined by a *participant employer* in accordance with state law. No person appointed on a *temporary appointment* will be considered an *employee*.

Employee Coverage Cbenefits with respect to the *employee* only.

Family Unit Limit Cthe dollar amount shown in the schedule of benefits has been incurred by three members of a family unit toward their *calendar year deductibles*. The *deductibles* of all additional members of that family unit will be considered satisfied for that year.

Fee Schedule Cthe schedule of maximum allowable charges for professional or *hospital* services adopted and promulgated by the *board of trustees*.

Future Medical Recovery C*recovery* from another plan of expenses contemplated to be necessary to complete medical *treatment* of the *covered person*.

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

Health Insurance Coverage Cbenefits consisting of medical care (provided directly, through insurance or *reimbursement*, or otherwise) under any *hospital* or medical service policy or certificate, *hospital* or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described pursuant to the Health Insurance Portability and Accountability Act are not treated as benefits consisting of medical care.

Health Maintenance Organization (HMO) Cany 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 Cthe Health Insurance Portability and Accountability Act of 1996 (USA Public Law 104-191).

Hospital Can institution, which meets all the following requirements:

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

Incurred Date C the date upon which 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 pro rated share of the charge.

Inpatient Confinement C a *hospital* stay, which is equal to or exceeds 24 hours.

Lifetime Maximum Benefit C means the total amount of benefits that will be paid under the *plan* for all eligible expenses incurred by a *covered person*.

Medically Necessary C a service or *treatment* which, in the judgement of the *program*:

1. is appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

2. is not primarily *custodial care*.

Medicare C the health insurance available through *Medicare* laws enacted by the Congress of the United States.

Network Pharmacy C a pharmacy, which 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 C the application of any activity in which one engages 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.

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

Pain Rehabilitation Control and/or Therapy C many program designed to develop the individual's ability to control or tolerate chronic pain.

Participant Employer C a state entity, school board or a state political subdivision authorized by law to participate in the *program*.

Physical Therapy C the evaluation of physical status as related to functional abilities and *treatment* procedures as indicated by that evaluation.

Physician C

1. *Physician* means the following persons, licensed to practice their respective professional skills by reason of statutory authority:

- a. doctor of medicine (M.D.);
- b. doctor of dental surgery (D.D.S.);
- c. doctor of dental medicine (D.M.D.);
- d. doctor of osteopathy (D.O.);

e. doctor of podiatric medicine (D.P.M.);

f. doctor of chiropractic (D.C.);

g. doctor of optometry (O.D.);

h. psychologist meeting the requirements of the National Register of Health Service Providers in Psychology;

i. board certified social workers who are a members of an approved clinical social work registry or employed by the United States, the State of Louisiana, or a Louisiana parish or municipality, if performing professional services as a part of the duties for which he is employed;

j. mental health counselors who are licensed by the state in which they practice;

k. substance abuse counselors who are licensed by the state in which they practice.

2. The term *physician* does not include social workers, who are not board certified; interns; residents; or fellows enrolled in a residency training program regardless of any other title by which he is designated or his position on the medical staff of a *hospital*. A senior resident, for example, who is referred to as an assistant attending surgeon or an associate *physician*, is considered a resident since the senior year of the residency is essential to completion of the training program. Charges made by a *physician*, who is on the faculty of a state medical school, or on the staff of a state *hospital*, will be considered a covered expense if the charges are made in connection with the *treatment* of a disease, illness, accident or injury covered under this *plan*, and if the *physician* would have charged a fee for the services in the absence of this provision.

3. It is the specific intent and purpose of the *program* to exclude *reimbursement* to the *covered person* for services rendered by social workers who are not board certified; and intern, resident, or fellow enrolled in a residency training program regardless of whether the intern, resident, or fellow was under supervision of a *physician* or regardless of the circumstances under which services were rendered.

4. The term *physician* does not include a practicing medical doctor in the capacity of supervising interns, residents, senior residents, or fellows enrolled in a training program, who does not personally perform a surgical procedure or provide medical *treatment* to the *covered person*.

Plan C coverage under this contract including *PPO* benefits, prescription drug benefits, mental health and substance abuse benefits and comprehensive medical benefits.

Plan Member C a *covered person* other than a *dependent*.

PPO C 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.

EMPLOYEE BENEFITS

Program the State Employees Group Benefits Program as administered by the *board of trustees*.

Recovery monies paid to the *covered person* by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical or dental charges covered by the *program*.

Referee a hearing officer employed by the board, to whom an *appeal* may be referred for hearing.

Rehabilitation and Rehabilitation Therapy care concerned with the management of patients with impairments of function due to disease, illness, accident or injury.

Reimbursement repayment to the *program* for medical or dental benefits that it has paid toward care and *treatment* of the injury or sickness.

Rest Cure care provided in a sanitarium, nursing home or other facility and designed to provide *custodial care* and provide for the mental and physical well being of an individual.

Retiree

1. an individual who was a covered *employee*, immediately prior to the date of retirement and who, upon retirement:

a. immediately received retirement benefits from an approved state or governmental agency defined benefit plan; or

b. was not eligible for participation in such a plan or had legally opted to not participate in such a plan; and

i. began employment prior to September 15, 1979, has 10 years of continuous state service and has reached the age of 65; or

ii. began employment after September 16, 1979, has 10 years of continuous state service and has reached the age of 70; or

iii. 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

iv. 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; or

c. 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 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 State Employees Group Benefits Program.

2. *retiree* also means an individual who was a covered *employee* who 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 all *hospital* expenses necessary to maintain and sustain a *covered person* during a confinement, including but 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 charge.

Subrogation 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 as well as medical services rendered in the care of a *covered person*.

Well-Adult Care 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, and billed by that *physician* with wellness procedure and diagnosis codes. All other health services coded with wellness procedures and diagnosis codes are excluded.

Well-Baby Care routine care to a well newborn infant from the date of birth until age 1.

Well-Child Care routine physical examinations, active immunizations, check-ups and office visits to a *physician*, and billed by that *physician*, except for the *treatment* and/or diagnosis of a specific illness, from age 1 to age 16.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999).

Chapter 7. Schedule of Benefits PPO

§701. Comprehensive Medical Benefits

A. Eligible expenses for professional medical services are reimbursed on a *fee schedule* of maximum allowable charges. All eligible expenses are determined in accordance with *plan* limitations and exclusions.

Lifetime maximum for all benefits except outpatient prescription drug benefits per person	\$ 1,000,000
Lifetime maximum for all outpatient prescription drug benefits per person	\$ 250,000

1. *Deductibles*

Inpatient <i>deductible</i> per day, maximum of 5 days per admission (waived for admissions at <i>PPO hospitals</i>)	\$ 50
Emergency room charges for each visit unless the <i>covered person</i> is <i>hospitalized</i> immediately following emergency room treatment (prior to and in addition to <i>calendar year deductible</i>)	\$ 150
Professional and other eligible expenses <i>Employees and dependents of employees</i> Per person, per <i>calendar year</i>	\$ 500
Professional and other eligible expenses, <i>retirees</i> and <i>dependents of retirees</i> , per person, per <i>calendar year</i>	\$ 300
Family unit maximum (3 individual <i>deductibles</i>)	\$ 900

2. Percentage Payable after Satisfaction of Applicable *Deductibles*

Eligible expenses incurred at a <i>PPO</i>	90%
Eligible expenses incurred at a non- <i>PPO</i> when <i>plan member</i> resides outside of Louisiana	90%
Eligible expenses incurred at a non- <i>PPO</i> when <i>plan member</i> resides in Louisiana	70%
Eligible expenses incurred when <i>Medicare</i> or other <i>group health plan</i> is primary, and after <i>Medicare</i> reduction	80%
Eligible expenses in excess of \$10,000 per <i>calendar year</i> per person	100%
<ul style="list-style-type: none"> Eligible expenses at <i>PPO</i> are based upon contracted rates. <i>PPO</i> discounts are not eligible expenses and do not apply to the \$10,000 threshold. Eligible expenses at non-<i>PPO</i> are based upon the OGB's <i>fee schedule</i>. Charges in excess of the <i>fee schedule</i> are not eligible expenses and do not apply to the \$10,000 threshold. 	

3. Eligible *Hospital Expenses*¹

<i>Hospital room and board</i> not to exceed the average semi-private room rate	See % payable after <i>deductible</i> - above
Intensive care unit not to exceed 2 1/2 times the <i>hospital's</i> average semi-private room rate	See % payable after <i>deductible</i> - above
Miscellaneous expenses	See % payable after <i>deductible</i> - above

4. Prescription Drugs (Not subject to *deductible*)

<i>Network pharmacy</i>	Member pays 50 percent of drug costs at point of purchase.
Maximum co-payment	\$40 per prescription dispensed
Out-of-pocket threshold	\$1000 per person, per <i>calendar year</i>
Co-pay after threshold is reached:	
Brand	\$15
Generic	No co-pay
<i>Plan</i> pays balance of eligible expense	
NOTE: Out-of-pocket thresholdC-\$500 per person, for the period July 1-December 31, 2001	
Non- <i>network pharmacy</i>	Member pays full drug costs at point of purchase.
In-state	<i>Reimbursement</i> limited to 50% of amount payable by <i>plan</i> at <i>network pharmacy</i>
Out-of-state	<i>Reimbursement</i> limited to 80% of amount payable by <i>plan</i> at <i>network pharmacy</i>

B. Dental Surgery Benefit for Specified Procedure

Percentage payable (<i>deductible</i> waived)	100%
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C. Well Care

1. Well Baby

Birth to age 1C all office visits for scheduled immunizations and screenings	See % payable after <i>deductible</i>
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2. Well Child

Age 1-2C3 office visits per year for scheduled immunizations and screenings	See % payable after <i>deductible</i>
Age 3-15C1 office visit per year for scheduled immunizations and screenings	See % payable after <i>deductible</i>

3. Well Adult (No *deductible*C limited to a maximum benefit of \$200)

Age 16-39C1 physical every 3 years	² See % payable below
Age 40-49C1 physical every 2 years	² See % payable below
Age 50 and overC1 physical every year	² See % payable below

²*PPO* in-state and non-Louisiana residentsC 100 percent of eligible expenses up to the maximum benefit;
Non-*PPO* in-stateC 70 percent of eligible expenses up to 70 percent of the maximum benefit.

D. *Durable Medical Equipment*

Lifetime maximum per <i>covered person</i>	\$ 50,000
Percentage payable	See % payable after <i>deductible</i>

E. Facility Fees, Maximum Allowable Charges. Unless otherwise provided by contract between the *program* and the provider, the maximum allowable charges for facility fees for facilities located within the state of Louisiana shall be.

Facility Type/Charges	Maximum Allowable Charges
Medical	\$1,500/day
Surgical	\$2,000/day
ICU, NICU, CCU	\$3,000/day
Cardiovascular Surgery	\$5,000/day
<i>Rehabilitation</i>	\$750/day
Ambulatory (Outpatient) Surgery	\$3,000 max/occurrence

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1843 (October 1999), amended LR 26:488 (March 2000), LR 27:719 (May 2001), LR 27:720 (May 2001), LR 27:722 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1887 (November 2001), LR 28:2345 (November 2002).

EMPLOYEE BENEFITS

§703. Mental Health and Substance Abuse

NOTE: Requires prior approval of services.

A. Deductibles

Annual per person (separate from comprehensive medical benefits <i>deductible</i>)	\$ 200
Inpatient (maximum 5 days; \$250 per stay)	\$ 50 per day

B. Benefits

Benefits	
80% of the first \$5,000 of eligible expenses	
100% of eligible expenses over \$5,000 until the lifetime maximum for all <i>plan</i> benefits is reached	
Up to a maximum of 45 inpatient days per person, per <i>calendar year</i>	
Up to a maximum of 52 outpatient visits per person, per <i>calendar year</i> , inclusive of the intensive outpatient program	

NOTE: Two days of partial hospitalization or two days of residential *treatment* center hospitalization may be traded for each inpatient day of *treatment* that is available under the 45-day *calendar year* maximum for inpatient *treatment*. A

residential *treatment* center is a 24-hour mental health or substance abuse, non-acute care *treatment* setting for active *treatment* interventions directed at the amelioration of the specific impairments that led to admission. Partial hospitalization is a level of care where the patient remains in the *hospital* less than 24 hours.

Expenses incurred for emergency services will only be reimbursed 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*.

¹Subject to Pre-Admission Certification (PAC) Guidelines

²Non-*PPO/EPO* in-state benefit limited to 50 percent of maximum; non-*PPO/EPO* out-of-state benefit limited to 80 percent of maximum.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1844 (October 1999).

Title 32 EMPLOYEE BENEFITS

Part V. Exclusive Provider (EPO)C Plan of Benefits

Chapter 1. Eligibility

§101. Persons to be Covered

Note: Eligibility requirements apply to all participants in the program, whether in the *PPO plan*, the *EPO plan* or an *HMO plan*.

A. Employee Coverage

1. *Employee*Csee §601.

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 at a later date to be covered separately, 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 the benefits.

3. Effective Dates of Coverage, New *Employee*. Coverage for each *employee* who completes the applicable enrollment form and agrees to make the required payroll contributions to his *participant employer* is to be effective as follows.

a. If employment begins on the first day of the month, coverage is effective the first day of the following month.

b. If employment begins on the second day of the month or after, coverage is effective the first day of the second month following employment.

c. *Employee coverage* will not become effective unless the *employee* completes an application for coverage within 30 days following the date of employment. An *employee* who completes an application after 30 days following the date of employment will be considered an overdue applicant.

4. Employee Deferral Rule

a. If an *employee* is confined at home, in a *hospital*, nursing home, or elsewhere, by reason of disease, illness, accident, or injury on the date the *employee* would otherwise have become covered under this *plan*, the effective date of the *employee* and *dependent coverage* will be deferred until the date the *employee* returns to work for one full day.

b. The return to active work requirement will not serve to defer an *employee's* effective date of coverage in the event that the *employee's* normal place of employment is not open on the day he would otherwise have returned to work. If an *employee* is on an approved leave of absence on the day he would normally have returned to work, coverage will become effective on the day he returns to work.

5. Re-Enrollment, Previous Employment

a. An *employee* whose employment terminated while covered, who is re-employed within 12 months of the date of termination will be considered a re-enrollment, previous employment applicant. A re-enrollment previous employment applicant will be eligible for only that classification of coverage (*employee*, *employee* and one *dependent*, family) in force on the effective date of termination.

b. If an *employee* acquires an additional *dependent* during the period of termination, that *dependent* may be covered if added within 30 days of re-employment.

6. 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 Section does not apply to members of school boards or members of state boards or commissions who are defined by the *participant employer* as full time *employees*.

7. Legislative Assistants. Legislative assistants are eligible to participate in the *plan* if they are declared to be full-time *employees* by the *participant employer* and have at least one year of experience or receive at least 80 percent of their total compensation as legislative assistants.

8. Pre-Existing Condition (PEC)CNew *employees* (on and after July 1, 2001)

a. The terms of the following paragraphs apply to all eligible *employees* whose employment with a *participant employer* commences on or after July 1, 2001, and to the *dependents* of such *employees*.

b. The *program* may require that such applicants complete a "Statement of Physical Condition" and an "Acknowledgement of Pre-existing Condition" form.

c. Medical expenses incurred during the first 12 months that coverage for the *employee* and/or *dependent* is in force under the *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 effective date of coverage. The provisions of this Section do not apply to pregnancy.

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 of 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. *Retirees* of *participant employers* are eligible for *retiree coverage* under this *plan*.

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. *Retirees* will not be eligible for coverage as overdue applicants.

b. A *retiree* retired from one *participant employer* may be covered as an *employee* of another *participant employer* or as a *retiree* of the *participant employer* from which he retired, but not both. In order to retain eligibility, upon termination of employment from the later *participant employer*, the *retiree* must return to the retirement group of his original *participant employer* within 30 days.

c. The *retiree* is responsible for notifying his initial *participant employer* of re-employment and return to *retiree* status.

C. *Dependent Coverage*

1. Eligibility. A *dependent* of an eligible *employee* or *retiree* will be eligible for *dependent coverage* on the later 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 for *dependents* 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*, if application is made within 30 days of the date of eligibility.

c. *Dependent Deferral Rule*. If a *dependent*, other than a newborn child or legal spouse of an *employee* is confined at home, in a nursing home, *hospital*, or elsewhere by reason of disease, illness, accident, or injury on the date he would otherwise become covered under this *plan*, the effective date of that *dependent's* coverage will be deferred until the date confinement terminates or *disability* ends, whichever is later.

D. Pre-Existing Condition (PEC)C 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 provisions of this Section do not apply to military reservists or national guardsmen ordered to active duty who return to state service and reapply for coverage with the *program* within 30 days of the date of reemployment. Coverage will be reinstated effective on the date of return to state service. The effective date of coverage will be:

a. the first day of the month following the date of receipt by the *program* of all required forms prior to the fifteenth of the month;

b. the first day of the second month following the date of the receipt by the *program* of all required forms on or after the fifteenth of the month.

2. The *program* will require that all overdue applicants complete a "Statement of Physical Condition" and an "Acknowledgement of Pre-existing Condition" form.

3. Medical expenses incurred during the first 12 months that coverage for the *employee* and/or *dependent* is in force under the *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 6-month period immediately prior to the effective date of coverage. The provisions of this Section do not apply to pregnancy.

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 without a break of 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 EnrollmentsCHIPAA. 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 has 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* 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 HIPPA.

2. After Acquiring *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 the termination date of the prior coverage or the date the new *dependent* is acquired. Persons eligible for special enrollment for which an application is made more than 30 days after eligibility will be considered overdue applicants subject to a pre-existing condition limitation.

b. The effective date of coverage shall be:

i. for loss of other coverage or marriage, the first day of the month following the date of receipt by the *program* of all required forms for enrollment;

ii. for birth of a *dependent*, the date of birth;

iii. for adoption, the date of adoption or placement for adoption.

c. Special enrollment applicants must complete acknowledgment of pre-existing condition and statement of physical condition forms.

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 6-month period immediately prior to the enrollment date. The provisions of this Section do not apply to pregnancy.

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 a coverage effective date of July 1. Transfer of coverage from the *plan* to the HMO or vice-versa will only be allowed during this annual enrollment period. Transfer of coverage will also be allowed as a consequence 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 July 1, the *plan*, which is providing coverage prior to July 1, will continue to provide coverage up to the date of discharge from the *hospital*.

H. *Medicare* Risk HMO Option for *Retirees*. *Retirees* who are eligible to participate in a *Medicare* Risk HMO plan who cancel coverage with the *program* upon enrollment in a *Medicare* Risk HMO plan may re-enroll in the *program* upon withdrawal from or termination of coverage in the *Medicare* Risk HMO 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801.C and 802.B.(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1804 (October 1999), amended LR 27:718 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:2339 (November 2002).

§103. Continued Coverage

A. Leave of Absence. If an *employee* is allowed an approved leave of absence by his *participant employer*, he may retain his coverage for up to one year, if the premium is paid. Failure to do so will result in cancellation of coverage. 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.

EMPLOYEE BENEFITS

2. If a *participant employer* withdraws from the *plan*, health and life coverage for all *covered persons* will terminate as of the effective date of withdrawal.

C. *Surviving Dependents/Spouse*. The provisions of this Section are applicable to surviving *dependents* who elect to continue coverage following the death of an *employee* or *retiree*. On or after July 1, 1999, eligibility ceases for a *covered person* who becomes eligible for coverage in a *group health plan* other than *Medicare*. Coverage under the *group health plan* may be subject to *HIPAA*.

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 until the surviving spouse becomes eligible for coverage in a *group health plan* other than *Medicare*.

b. The surviving *children* of an *employee* or *retiree* may continue coverage until they are 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/spouse* will be entitled to receive the same *participant employer* premium contributions as *employees* and *retirees*.

d. Coverage provided by the civilian health and medical program of the uniform services 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 events occurs:

- i. failure to pay the applicable premium;
- ii. death of the surviving spouse;

iii. on or after July 1, 1999, becomes eligible for coverage 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;
- ii. on or after July 1, 1999, becomes eligible for coverage under any *group health plan* other than *Medicare*;
- iii. the attainment of the termination age for *children*.

D. *Over-Age Dependents*. If an unmarried, never married *dependent child* is incapable of self-sustaining employment by reason of mental retardation or physical incapacity and became incapable prior to the termination age for *children* and is dependent upon the covered *employee* for support, the coverage for the *dependent child* may be continued for the duration of incapacity.

1. Prior to attainment of age 21, the *program* must receive documentation for *dependents* who are mentally retarded or who have a physical incapacity.

2. For purposes of this Section, mental illness does not constitute mental retardation.

3. The *program* may require that the covered *employee* submit current proof from a licensed medical doctor of continued mental retardation or physical incapacity as often as it may deem necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1806 (October 1999).

§105. COBRA

A. *Employees*

1. Benefits 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, 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 at the *employee's* own expense. *Employees* terminated for gross misconduct are not eligible for *COBRA*.

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. Application for continued coverage must be made in writing to the *program* within 60 days of the date of notification and premium payment must be made within 45 days of the date the *employee* elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. Coverage under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium;
- b. 18 months from the date coverage would have terminated;
- c. entitlement to *Medicare*;
- d. coverage under a *group health plan*, except when subject to a pre-existing condition limitation.

B. Surviving *Dependents*

1. Benefits 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 notification. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated.

a. Coverage for the surviving *dependents* under this Section will continue until the earliest of the following:

- i. failure to pay the applicable premium;
- ii. death of the surviving spouse;
- iii. entitlement to *Medicare*;
- iv. coverage under a *group health plan*, except when subject to a pre-existing condition limitation.

b. Coverage for a surviving *dependent* child under this Section will continue until the earliest of the following:

- i. failure to pay the applicable premium;
- ii. 36 months beyond the date coverage would have terminated;
- iii. entitlement to *Medicare*;
- iv. coverage under a *group health plan*, except when subject to a pre-existing condition.

C. Divorced Spouse

1. Coverage under this *plan* 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. 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 notification. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have terminated.

2. Coverage for the divorced spouse under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium;
- b. 36 months beyond the date coverage would have terminated;
- c. entitlement to *Medicare*;
- d. coverage under a *group health plan*, except when subject to a pre-existing condition.

D. *Dependent Children*

1. Benefits 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. 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.

2. 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 the continued coverage is elected, for coverage retroactive to the date coverage would have terminated.

3. Coverage for *children* under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium;
- b. 36 months beyond the date coverage would have terminated;
- c. entitlement to *Medicare*;
- d. coverage under a *group health plan*, except when subject to a pre-existing condition.

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*;

2. Then, the spouse and/or *dependent* child may elect to continue coverage at their own expense. Coverage will not be continued beyond 36 months from the date coverage would have terminated.

F. *Dependents* of Non-Participating Terminated *Employee*

1. If an *employee* no longer meets the definition of an *employee*, or a 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 their own expense. The elected coverage will be subject to the notification and termination provisions.

2. In the event a *dependent child*, covered under the provisions of the preceding paragraph no longer meets the definition of an eligible covered *dependent*, he or she may elect to continue coverage at his or her own expense. Coverage cannot be continued beyond 36 months from the date coverage would have terminated.

G. 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 *employee* and *retirees*.

H. Disability COBRA

1. If a covered *employee* or covered *dependent* is determined by social security or by the *program* staff (in the case of a person who is ineligible for social security *disability* 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 terminated. To qualify the *covered person* must:

a. submit a copy of his or her social security *disability* determination to the *program* before the initial 18-month continued coverage period expires and within 60 days after the date of issuance of the social security determination; or

b. submit proof of total *disability* to the *program* before the initial 18-month continued coverage period expires.

2. 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.

3. The staff and medical director of the *program* will make this 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.

4. Coverage under this Section will continue until the earliest of the following:

a. 30 days after the month in which social security 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 social security);

b. 29 months from the date coverage would have terminated;

I. *Medicare COBRA*. If an *employee* becomes entitled to *Medicare* on or 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 be the earliest of the following:

1. failure to pay the applicable premium;
2. 36 months beyond the date coverage would have terminated;
3. entitlement to *Medicare*;
4. coverage under a *group health plan*, except when subject to a pre-existing condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1807 (October 1999).

§107. Change of Classification

A. Adding or Deleting *Dependents*. The *plan member* must notify the *program* whenever a *dependent* is added to, or deleted from, the *plan member's* coverage, regardless of whether the addition or deletion would result 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, by reason of a change in family status (e.g., marriage, birth of child), the class of coverage is subject to change, effective on the date of the event, if application for the change is made within 30 days of the date of the event.

2. When the addition of a *dependent* results in the class of coverage being changed, the additional premium will be charged for the entire month if the date of change occurs on or before the fourteenth day of the month. If the date of change occurs on or after the fifteenth day of the month, additional premium will not be charged until the first day of the following month.

C. Notification of Change. It is the responsibility of the *employee* to notify the *program* of any change in classification of coverage affecting the *employee's* contribution amount. Any such failure later determined will be corrected on the first day of the following month.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999).

§109. Contributions

A. The state of Louisiana may make a contribution toward the cost of the *plan*, as determined on an annual basis by the legislature.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999).

Chapter 2. Termination of Coverage

§201. 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. on the date the *program* terminates;
2. on the date the group or agency employing the covered *employee* terminates or withdraws from the *program*;
3. on the contribution due date if the group or agency fails to pay the required contribution for the covered *employee*;
4. on the contribution due date if the *covered person* fails to make any contribution which is required for the continuation of his coverage;
5. on the last day of the month of the covered *employee's* death;
6. on the last day of the month in which the covered *employee* ceases to be eligible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999).

§203. 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. on the last day of the month the *employee* ceases to be covered.
2. on 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, on 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*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999).

Chapter 3. Medical Benefits

§301. Medical Benefits Apply When Eligible Expenses Are Incurred by a Covered Person

A. Eligible Expenses. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable *deductibles*, limits of the *fee schedule*, schedule of benefits, exclusions and other provisions of the *plan*. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. *hospital care*. The medical services and supplies furnished by a *hospital* or ambulatory surgical center. covered charges for *room and board* will be payable as shown in the schedule of benefits;
2. 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;
5. laboratory examinations and diagnostic X-rays;
6. nuclear medicine and electroshock therapy;
7. blood and blood plasma, blood derivatives and blood processing, when not replaced;
8. surgical and medical supplies billed for *treatment* received in a *hospital* or ambulatory surgical center, and other covered provider's surgical and medical supplies as listed below:
 - a. cathetersCexternal and internal;
 - b. cervical collar;
 - c. leg bags for urinal drainage;
 - d. ostomy supplies;
 - 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;
 1. surgical trays (for certain procedures);
9. services of licensed physical, occupational or speech therapist when prescribed by a *physician* and pre-approved through outpatient procedure certification;
10. intravenous injections, solutions, and eligible related intravenous supplies;

EMPLOYEE BENEFITS

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; and

c. coverage remains continuously in effect with respect to the *covered person* during the course of the *treatment*; eligible expenses will be limited to the original estimated total cost of *treatment* as estimated at the time of initial *treatment*;

12. *durable medical equipment*, subject to the lifetime maximum payment limitation as listed in the schedule of benefits. The *program* will require written certification by the treating *physician* to substantiate the medical necessity for the equipment and the length of time it will be used;

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, 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. The *program* will consider a maximum up to \$350 less a \$50 copayment for transportation charges. Medical services and supplies will be considered separately;

b. licensed air ambulance service to a *hospital* with facilities to treat an illness or injury. The *program* will consider a maximum up to \$1,500 less a \$250 copayment. Medical services and supplies will be considered separately;

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;

19. acupuncture when rendered by a medical doctor;

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 by the state in which the services are rendered when:

a. prescribed by a licensed medical doctor;

b. services require the skills of and performed by a licensed physical therapist or licensed occupational therapist;

c. restorative potential exists;

d. meets the standard for medical practice;

e. reasonable and necessary for the *treatment* of the disease, illness, accident, injury or postoperative condition;

f. approved through outpatient procedure certification.

22. *cardiac rehabilitation* when:

a. rendered at a medical facility under the supervision of a *physician*;

b. rendered in connection with a myocardial infarction, angioplasty with or without stenting, or cardiac bypass surgery;

c. completed within 6 months following the qualifying event;

NOTE: Charges incurred for dietary instruction, educational services, behavior modification literature, health club membership, exercise equipment, preventative programs and any other items excluded by the *plan* are not covered.

23. routine physical examinations and immunizations as follows:

a. *well-baby care* expenses subject to the annual *deductible* and co-payments:

i. newborn facility and professional charges;

ii. birth to age 1C all office visits for scheduled immunizations and screening;

b. *well-child care* expenses subject to the annual *deductible* and co-payments:

i. age 1 to age 3C3 office visits per year for scheduled immunizations and screening;

ii. age 3 to age 16C1 office visit per year for scheduled immunizations and screening;

c. *well-adult care* expenses not subject to the annual *deductible*, but limited to a maximum benefit of \$200:

- i. age 16 to age 40 C1 physical every 3 years;
- ii. age 40 to age 50 C1 physical every 2 years;
- iii. age 50 and over C1 physical every year;

24. not subject to the annual *deductible*:

a. one pap test for cervical cancer per *calendar year*;

b. screening mammographic examinations performed according to the following schedule:

i. one baseline mammogram during the five-year period a person is 35-39 years of age;

ii. one mammogram every two *calendar years* for any person who is 40-49 years of age or more frequently if recommended by a *physician*;

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 twelve months for men over the age of 50 years, and as *medically necessary* for men over the age of 40 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. physician's assistants, perfusionists, and registered nurse assistants assisting in the operating room;

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*, such benefits not to exceed \$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.a. testing of sleep disorders only when the tests are performed at either:

i. a sleep study facility accredited by the American Sleep Disorders Association or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

ii. a sleep study facility located within a healthcare facility accredited by JCAHO;

b. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1810 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:478 (March 2002).

§303. Fee Schedule

A. The *fee schedule* sets the maximum fee that the *program* will allow for an eligible medical expense.

B. If the medical provider accepts an assignment of benefits, the *plan member* cannot be billed for amounts exceeding the *fee schedule*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1811 (October 1999).

§305. Automated Claims Adjusting

A. Auto audit is a 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 reduced amounts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1811 (October 1999).

§307. Utilization ReviewC Pre-Admission Certification, Continued Stay Review

A. Pre-admission certification (PAC) and continued stay review (CSR) establish the medical necessity and length of inpatient *hospital* confinement.

1. It is the *plan member's responsibility* to assure that PAC is obtained for non-*PPO* facilities.

2. It is the provider's responsibility to obtain PAC for *EPO* and *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 2 days or less. If the mother's stay exceeds or is expected to exceed 2 days, PAC is required within 24 hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, 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 scheduled caesarean section, it is required that PAC be obtained prior to or the day of admission.

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 48 hours of 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 percent on any confinement for which PAC was not obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999).

§309. Outpatient Procedure Certification (OPC)

A. OPC certifies that certain outpatient procedures and therapies are *medically necessary*.

1. It is the *plan member's* responsibility to assure that OPC is requested on services performed by non-*PPO* providers.

2. On services performed by an *EPO* or *PPO* provider, it is the provider's responsibility to obtain OPC. The *plan member* cannot be billed if the provider fails to do so.

B. OPC is required on the following procedures:

1. cataract;
2. laparoscopic cholecystectomy;
3. lithotripsy;
4. magnetic resonance imaging:
 - a. brain/head lower extremity;
 - b. upper extremity;
 - c. spine;
5. knee arthroscopy;
6. septoplasty;
7. therapies:
 - a. *physical therapy*;
 - b. speech therapy;
 - c. *occupational therapy*;
 - d. therapy with unlisted modality.

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

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.

D. Benefits otherwise payable for services rendered by a non-*PPO* provider will be reduced by 25 percent for any procedure or therapy on which OPC was not obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999).

§311. 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 that are not normally covered. To be eligible, the condition being treated must be a covered condition, and Case management must be approved prior to the service being rendered.

C. These charges are subject to the *deductible*, co-insurance, *fee schedule* and maximum benefit limitations.

D. The following criteria must be met:

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. If approved, case management may provide any of the following:

1. alternative care in special *rehabilitation* facilities;

2. alternative care in a skilled nursing facility/unit or swing bed (not nursing home), or the patient's home, subject to the *deductible* and coinsurance;

3. avoidance of complications by earlier *hospital* discharge, alternative care and training of the patient and/or family;

4. home health care services limited to 150 visits per *plan* year;

5. hospice care:

a. not subject to the *deductible*;

b. benefits are always payable at 80 percent, never at 100 percent;

6. private duty nursing care;

7. total parenteral nutrition, provided that home visits for TPN are not reimbursable separately;

8. enteral nutrition up to a single 90-day period for instances where through surgery or neuromuscular mechanisms the patient cannot maintain nutrition and the condition can reasonably be expected to improve during this one 90-day timespan.

F. Mental health and substance abuse *treatments* or conditions are not eligible for case management.

G. 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.

H. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999).

§313. 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. Expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care are subject to the *deductible*, co-insurance and the maximum benefit provisions of the *plan*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999).

§315. Medicare Reduction

A. If the patient has not chosen and paid a separate premium for the full coordination of benefits option, the charges will be reduced by whatever amounts are paid or payable by *Medicare*. The *program* requires written confirmation from the Social Security Administration or its successor if a person is not eligible for *Medicare* coverage. All provisions of this *plan*, including all limitations and exceptions, will be applied.

B. *Retiree* 100-*Medicare* COB. Upon enrollment and payment of the additional monthly premium, a *plan member* and his *dependents* may choose to have full coordination of benefits with *Medicare*. Enrollment must be made within 30 days of eligibility for *Medicare* or within 30 days of retirement if already eligible for *Medicare* and at the annual open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999).

§317. Exceptions and Exclusions for All Medical Benefits

A. No benefits are provided under this *plan* for:

1. cases covered, in whole or in part, by 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. convalescent, skilled nursing, sanitarium, or *custodial care* or *rest cure*;

3. expenses for elective, non-therapeutic voluntary abortion, although expenses for complications as a result are covered;

4. injuries sustained while in an aggressor role;

EMPLOYEE BENEFITS

5. expenses incurred as a result of the patient's attempt at a felony or misdemeanor;
6. expenses incurred by a *covered person* in connection with cosmetic surgery, unless necessary for the immediate repair of a deformity caused by a disease and/or injury which 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. expenses incurred for shoes and related items similar to wedges, cookies and arch supports;
8. any expense, except for actual out-of-pocket expenses, incurred by a member of a Health Maintenance Organization (HMO), Health Maintenance *Plan* (HMP) or other prepaid medical plan or medical services plan if the *covered person* is enrolled on a group (employer-sponsored) basis;
9. dental braces and orthodontic appliances (for whatever reason prescribed or utilized) and *treatment* of periodontal disease;
10. dentures, dental implants and any surgery for their use, except if needed as the result of an accident that meets the *program's* requirements;
11. medical services, *treatment* or prescription drugs provided without charge to the *covered person* or for which the *covered person* is not legally obligated to pay;
12. maternity expenses incurred by any person other than the *employee* or the *employee's* legal spouse;
13. personal convenience items including, but not limited to, admit kits, bedside kits, telephone and television, guest meals, beds, and similar items;
14. charges for services and supplies 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*;
15. services and supplies which are not *medically necessary*;
16. services rendered for remedial reading and recreational, visual and behavioral modification therapy, *pain rehabilitation control and/or therapy*, and dietary or educational instruction for all illnesses, other than diabetes;
17. services and supplies in connection with or related to gender dysphoria or reverse sterilization;
18. artificial organ implants, penile implants, transplantation of other than homo sapiens (human) organs;
19. expenses subsequent to the initial diagnosis, for infertility and complications, including, but not limited to, services, drugs, and 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;
20. 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, and any other items not normally considered medical supplies;
21. administrative fees, interest, penalties or sales tax;
22. marriage counseling and/or family relations counseling;
23. charges for services rendered over the telephone from a *physician* to a *covered person*;
24. radial keratotomy or any procedures for the correction of refractive errors;
25. speech therapy, except when ordered by a *physician* 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;
26. services and supplies related to obesity, surgery for excess fat in any area of the body, resection of excess skin or fat following weight loss or pregnancy;
27. hearing aids, or any examination to determine the fitting or necessity;
28. hair transplants;
29. routine physical examinations or immunizations not listed under eligible expenses;
30. diagnostic or *treatment* measures which are not recognized as generally accepted medical practice;
31. medical supplies not listed under eligible expenses;
32. *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;
33. expenses for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, dental procedures which fall under the guidelines of eligible dental accidents, 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;
34. genetic testing, except when determined to be *medically necessary* during a covered pregnancy;
35. *treatment* for temporomandibular joint dysfunction (TMJ), except as listed under eligible expenses;
36. services of a private-duty registered nurse (R.N.) or of a private-duty licensed practical nurse (L.P.N.);
37. breast thermograms;
38. services rendered by any provider related to the patient by blood, adoption or marriage;

39. facility fees for services rendered in a *physician's* office or in any facility not approved by the federal Health Care Financing Administration for payment of such fees under *Medicare*;

40. glucometers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), amended LR 26:487 (March 2000), LR 27:717 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:2340 (November 2002).

§319. Coordination of Benefits

A. Coordination of benefits is the order of payment when two or more plans are involved. When a patient is also covered by another plan, the plans will coordinate benefits.

B. 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, except for *Health Maintenance Organizations* or other types of employer-sponsored prepaid medical plans.

b. The plan that pays first will pay as if there were no other plan involved. The secondary and subsequent plans may pay the balance due up to 100% of the total allowable expense. No plan will pay benefits greater than it would have paid in the absence of coordination of benefits.

D. *Health Maintenance Organizations* (HMO). If a person is also covered as a *dependent* under a *Health Maintenance Organization* (HMO), the *program* will consider the HMO as the primary carrier. The *plan* will consider as eligible only those actual out-of-pocket expenses incurred that the patient is legally obligated to pay.

E. Preferred Provider Organizations (*PPO*). In the event that a *covered person* is also covered as a *dependent* under a *PPO* contract, the *plan* will consider as eligible only those expenses actually incurred by the *covered person* under the terms of the *PPO* contract, and for which the *covered person* is legally obligated to pay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1814 (October 1999).

§321. Exclusive Provider Program

A. The *program* may implement Exclusive Provider Organization (*EPO*) arrangements or other agreements to discount payable fees. The *program* reserves to itself the right to negotiate the amount of the discount, the incentives to be 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 would be on a *covered person* with only *Medicare* Part A, who did not also have *Medicare* Part B. The Part B charges would be eligible for *EPO* benefits.

1. 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 after applicable co-pays, as specified in the schedule of benefits. There is a contractual assignment to all *EPO* providers.

2. Point of Service *EPO* Regions (Areas)

a. The following regions are used to determine whether there is an *EPO* provider in the same area as the point of service.

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

b. If a non-*EPO* provider is used, then *PPO* benefits apply as described in this document.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1814 (October 1999).

§325. Prescription Drug Benefits

A. This *plan* allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor requiring a prescription and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a *covered person* as an inpatient *hospital* patient or an outpatient *hospital* patient, including insulin, Retin-A dispensed for *covered persons* under the age of 26, vitamin B12 injections, prescription potassium chloride, and over-the-counter diabetic supplies, including, but not limited to, strips, lancets, and swabs. In addition, this *plan* allows benefits, not to exceed \$200 per month, for

EMPLOYEE BENEFITS

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.

1. *Inherited Metabolic Disease*Ca disease caused by an inherited abnormality of body chemistry and shall be limited to:

- a. phenylketonuria (PKU);
- b. maple syrup urine disease (MSUD);
- c. methylmalonic acidemia (MMA);
- d. isovaleric acidemia (IVA);
- e. propionic acidemia;
- f. glutaric acidemia;
- g. urea cycle defects;
- h. tyrosinemia.

2. *Low Protein Food Products*Ca food product that is especially formulated to have less than one gram of protein per serving and is 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 a natural food that is naturally low in protein.

B. The following drugs, medicines, and related services 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. 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;
7. nutritional or parenteral therapy;
8. vitamins and minerals;
9. drugs available over the counter; and
10. serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting;
11. drugs for *treatment* of impotence, except following surgical removal of the prostate gland; and
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* document, the following apply to expenses incurred for outpatient prescription drugs.

1. Upon presentation of the Group Benefits *Program* 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 a maximum of \$40 per prescription dispensed. The *plan* will pay the balance of the eligible expense for prescription drugs dispensed at a *network pharmacy*. There is a \$1000 per person per *calendar year* out-of-pocket threshold for eligible prescription drug expenses. Once this threshold is reached, that is, the *plan member* has paid \$1000 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*.

NOTE: For the period July 1, 2001 through December 31, 2001, the out-of-pocket threshold will be \$500 per person. On January 1, the threshold will be re-set to \$1000 for *calendar year* 2002 and each subsequent year.

2. In the event the *plan member* does not present the Group Benefits *Program* 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 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 34-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 102-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 1-34 days the *plan member* will be responsible for payment of 50 percent of the cost of the drug, up to a maximum of \$40 per prescription dispensed.

ii. For a supply of 35-64 days the *plan member* will be responsible for payment of 50 percent of the cost of the drug, up to a maximum of \$80 per prescription dispensed.

iii. For a supply of 69-102 days the *plan member* will be responsible for payment of 50 percent of the cost of the drug, up to a maximum of \$120 per prescription dispensed.

iv. Once the out-of-pocket threshold for eligible prescription drug expenses is reached, the *plan member's* co-payment responsibility will be \$15 for a 1-34 days supply, \$30 for a 35-64 days supply, and \$45 for a 69-102 days supply, with no co-pay for up to a 102-days supply of generic drugs.

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

7. *Generic drug* C a chemically equivalent copy of a brand drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1815 (October 1999), amended LR 27:717 (May 2001), LR 27:718 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1886 (November 2001), LR 28:2340 (November 2002).

Chapter 4. Uniform Provisions

§401. Statement of Contractual Agreement

A. This written *plan* document as amended and any documents executed by or on behalf of the covered *employee* constitute the entire agreement between the parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999).

§403. Properly Submitted Claim

A. For *plan reimbursements*, all bills must show:

1. *employee's* name;
2. name of patient;
3. name, address, and telephone number of the provider of care;
4. diagnosis;
5. type of services rendered, with diagnosis and/or procedure codes;
6. date of service;
7. charges;
8. *employee's* member number;
9. provider tax identification number;
10. *Medicare* explanation of benefits, if applicable.

B. The *program* can require additional documentation in order to determine the extent of coverage or the appropriate *reimbursement*. Failure to furnish the requested information will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999).

§405. 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 claims is submitted to a clearinghouse or to the providers practice management system.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:476 (March 2002).

§407. Right to Receive and Release Information

A. The *program* may release to, or obtain from any company, organization, or person, without consent of or notice to any person, any information regarding any person which the *program* deems necessary to carry out the provisions of this *plan*, or like terms of any plan, or to determine how, or if, they apply. Any claimant under this *plan* must furnish to the *program* any information necessary to implement this provision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999).

§409. Legal Limitations

A. A *plan member* must exhaust the administrative claims review procedure 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 is required to be filed or more than 30 days after mailing of the notice of decision of the administrative claims *committee*, whichever is later.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:477 (March 2002).

§411. Benefit Payment to Other Group Health Plans

A. When payments, which should have been made under this *plan*, have been made by another *group health plan*, the *program* may pay to the other plan the sum proper to satisfy the terms of this *plan* document.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999).

§413. Recovery of Overpayments

A. 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 percent of the overpayment or \$1,000 whichever is greater. The defendant will also be responsible for court costs and legal interest from date of judicial demand until paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999).

§415. Third Party Recovery Provision

A. Right of *Subrogation* and *Reimbursement*. When this provision applies, the *covered person* may incur medical or dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the *covered person* may have a claim against the third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this *plan* for those incurred medical or dental expenses automatically assigns to the *program* any rights the *covered person* may have to recover payments from any third party or insurer. This right allows the *program* to pursue any claim which the *covered person* has against any third party, or insurer, whether or not the *covered person* chooses to pursue that claim. The *program* may make a claim directly against the third party or insurer, but in any event, the *program* has a lien on any amount recovered by the *covered person* whether or not designated as payment for medical expenses. This lien will remain in effect until the *program* is repaid in full. The *program* reserves the right to recover either from the liable third party or the *covered person*. The *covered person*:

1. automatically assigns to the *program* his or her rights against any third party or insurer when this provision applies;
2. must notify the *program* of a pending third-party claim; and
3. must repay to the *program* the benefits paid on his or her behalf out of the *recovery* made from the third party or insurer.

B. Amount Subject to *Subrogation* or *Reimbursement*

1. The *covered person* agrees to recognize the *program's* right to *subrogation* and *reimbursement*. These rights provide the *program* with a priority over any funds paid by a third party to a *covered person* relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

2. Notwithstanding its priority to funds, the *program's subrogation* and *reimbursement* rights, as well as the rights assigned to it, are limited to the extent to which the *program* has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the *program*.

3. When a right of *recovery* exists, the *covered person* will cooperate and provide requested information as well as doing whatever else is needed to secure the *program's* right of *subrogation* and *reimbursement* as a condition to having the *program* make payments. In addition, the *covered person* will do nothing to prejudice the right of the *program* to subrogate or seek *reimbursement*.

4. This right of refund also applies when a *covered person* recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any liability plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1817 (October 1999).

§417. Employer Responsibility

A. It is the responsibility of the *participant employer* to submit enrollment and change forms and all other necessary documentation on behalf of their *employees* to the *program*. *Employees* of a *participant employer* will not by virtue of furnishing any documentation to the *program* on behalf of a *plan member*, be considered agents of the *program*, and no representation made by any such person at any time will change the provisions of this *plan*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1817 (October 1999).

§419. Program Responsibility

A. The *program* will administer the *plan* in accordance with the terms of the *plan* document, state and federal law, and its established policies, interpretations, practices, and procedures. It is the express intent of this *program* that the *board of trustees* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *plan*, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to *covered person's* rights, and to decide questions of *plan* document interpretation and those of fact relating to the *plan* document. The decisions of the *board of trustees* or its *committees* will be final and binding on all interested parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1817 (October 1999).

§421. 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 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1817 (October 1999).

§423. Plan Document and/or Contract Amendments or Termination

A. The *program* has the statutory responsibility of providing health and accident and death benefits for *covered persons* to the extent that funds are available. The *program* reserves to itself the right to terminate or amend the eligibility and benefit provisions of its *plan* document from time to time as it may deem necessary to prudently discharge its duties. Termination or 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 participant, whether active or retired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1818 (October 1999).

Chapter 5. Claims Review and Appeal

§501. Administrative Review

NOTE: This Section establishes and explains the procedures for review of benefit and eligibility decisions by the *program*.

NOTE: Form §501-513 redesignated herein as §501.A-D.

A. Administrative Claims Review

1. The *covered person* may request from the *Program* a review of any claim for benefits or eligibility. The written

request must include the name of the *covered person*, member number, the name of the patient, the name of the provider, dates of service and should clearly state the reasons for the *appeal*.

2. 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

1. 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 to recover benefits allegedly payable under the *program*.

C. Administrative Claims *Committee*

1. The *CEO* will appoint an administrative claims *committee* (the *committee*) to consider all such requests for review and to ascertain whether the initial determination was made in accordance with the *plan* document.

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. Upon completion of the review the *committee* will render its decision which will be based on the *plan* document and the information included in the record. The decision will contain a statement of reasons for the decision. A copy of the decision will be mailed to the *covered person* and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801.C and 802.B.(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1818 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:477 (March 2002), LR 28:2340 (November 2002).

§503. Appeals from Medical Necessity Determinations

NOTE: The following provisions will govern appeals from adverse determinations based upon medical necessity by OGB's Utilization Review Organization (URO) pursuant to Article 3, Section IV of this document.

A. First level *appeal*. Within 60 days following the date of an adverse initial determination based upon medical necessity, the *covered person*, or the provider acting on behalf of the *covered person*, may request a first level *appeal*.

EMPLOYEE BENEFITS

1. Each such *appeal* will be reviewed within the URO by a health care professional who has appropriate expertise.

2. The URO will provide written notice of its decision.

B. Second level review. Within 30-days following the date of the notice of an adverse decision on a first level *appeal*, a *covered person* may request a second level review.

1. Each such second level review will be considered by a panel within the URO that includes health care professionals who have appropriate expertise and will be evaluated by a clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed.

a. The review panel will schedule and hold a review meeting, and written notice of the time and place of the review meeting will be given to the *covered person* at least fifteen working days in advance.

b. The *covered person* may:

i. present his/her case to the review panel;

ii. submit supporting material and provide testimony in person or in writing or affidavit both before and at the review meeting; and

iii. ask questions of any representative of the URO.

c. If 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 written notice of its decision on the second level review.

C. External Review. Within 60 days after receipt of notice of a second level *appeal* adverse determination, the *covered person* whose medical care was the subject of such determination, with the concurrence of the treating health care provider, may submit request for an external review to the URO.

1. The URO will provide the 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.

4. An external review decision will be binding on the URO, on OGB and on the covered regarding the medical necessity determination.

D. Expedited Appeals

1. An expedited *appeal* may be initiated by the *covered person*, with the consent of the treating health care

professional, or the 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. any request concerning an admission, availability of care, continued stay, or health care service for a *covered person* who has received emergency services but has not been discharged from a facility.

2. In an expedited *appeal* the URO will make a decision and notify the *covered person*, or the provider acting on behalf of the *covered person*, as expeditiously as the *covered person's* medical condition requires, but in no event more than seventy-two hours after the *appeal* is commenced.

3. The URO will provide written confirmation of its decision concerning an expedited *appeal* if the initial notification is not in writing.

4. In any case where the expedited *appeal* does not resolve a difference of opinion between the URO and the *covered person*, or the provider acting on behalf of the *covered person*, such provider may request a second level review of the adverse determination.

E. Expedited External Review of Urgent Care Requests

1. When the *covered person* receives an adverse determination involving an emergency medical condition of the *covered person* 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 will be binding on the URO, on OGB and on the covered regarding the medical necessity determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801.C and 802.B.(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1818 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:477 (March 2002), LR 28:2341 (November 2002).

Chapter 6. Definitions

§601. Definitions

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

*Benefit Payment*C payment of eligible expenses incurred by a *covered person* during a *calendar year* at the rate shown under percentage payable in the schedule of benefits.

*Board of Trustees*C the entity created and empowered to administer the State Employees Group Benefits *Program*.

*Calendar Year*C that period commencing at 12:01 a.m., January 1, standard time, at the address of the *employee*, or the date the *covered person* first becomes covered under the *plan* and continuing until 12:01 a.m., standard time, at the address of the *employee* on the next following January 1. Each successive *calendar year* will be the period from 12:01 a.m., January 1, standard time, at the address of the *employee* to 12:01 a.m., the next following January 1.

*CEO*C the Chief Executive Officer of the *program*.

*Children*C

1. any natural or legally adopted *children* of the *employee* and/or the *employee's* legal spouse dependent upon the *employee* for support;

2. any *children* in the process of being adopted by the *employee* through an agency adoption who are living in the household of the *employee* and who are or will be included as a *dependent* of the *employee's* federal income tax return for the current or next tax year (if filing is required);

3. other *children* for whom the *employee* has legal custody, who live in the household of the *employee*, and who are or will be included as a *dependent* on the *employee's* federal income tax return for the current or next tax year (if filing is required);

4. grandchildren for whom the *employee* does not have legal custody, who are dependent upon the *employee* for support, and one of whose parents 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 *plan member*, execute an acknowledgement of paternity.

NOTE: If *dependent* parent becomes ineligible, the grandchild becomes ineligible for coverage, unless the *employee* has legal custody of the grandchild.

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

*Committee*C the grievance *committee* of the board.

*Covered Person*C an active or retired *employee*, or his 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 being made.

*Custodial Care*C care designed essentially to assist an individual to meet his activities of daily living (i.e. services which constitute personal care such as help in walking, getting in and out of bed, assisting in bathing, dressing, feeding, using the toilet and care which does not require admission to the *hospital* or other institution for the *treatment* of a disease, illness, accident or injury, or for the performance of surgery; or, care primarily to provide *room and board* with or without routine nursing care, training in personal hygiene and other forms of self-care) and supervisory care by a doctor for a person who is mentally or physically incapacitated and who is not under specific medical, surgical or psychiatric *treatment* to reduce the incapacity to the extent necessary to enable the patient to live outside an institution providing medical care, or when, despite *treatment*, there is not reasonable likelihood that the incapacity will be so reduced.

*Date Acquired*C the date a *dependent* of a covered *employee* is acquired in the following instance and on the following dates only:

1. legal spouseC date of marriage;

2. *children*C

a. natural *children*C the date of birth;

b. *children* in the process of being adopted:

i. agency adoptionC the date the adoption contract was executed by the *employee* and the adoption agency;

ii. private adoptionC the date of the execution of the act of voluntary surrender in favor of the *employee*, if the *program* is furnished with certification by the appropriate clerk of court setting forth the date of execution of the act and the date that said act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;

c. other *children* living in the household of the covered *employee* who are or will be included as a *dependent* on the *employee's* federal income tax returnC the date of the court order granting legal custody.

d. grandchildren for whom the *employee* does not have legal custody, who are dependent upon the *employee* for support, and one of whose parents is a covered *dependent* as defined:

i. the date of birth, if all the requirements are met at the time of birth; or

ii. the date on which the coverage becomes effective for the covered *dependent*, if all the requirements are not met at the time of birth.

*Deductible*C the amount of covered charges for which no benefits will be paid. Before benefits can be paid in a *calendar year*, a *covered person* must meet the *deductible* shown in the schedule of benefits.

EMPLOYEE BENEFITS

Dependent any of the following persons who are enrolled for coverage as *dependents*, if they are not also covered as an *employee*:

1. the covered *employee's* legal spouse;
2. any (never married) *children* from date of birth (must be added to coverage within 30 days from *date acquired* by completing appropriate enrollment documents) up to 21 years of age, dependent upon the *employee* for support;
3. any unmarried (never married) *children* 21 years of age, but under 24 years of age, who are enrolled and attending classes as full-time students and who depend upon the *employee* for support. The term full-time student means students who are enrolled at an accredited college or university, or at a vocational, technical, or vocational-technical or trade school or institute, or secondary school, for the number of hours or courses which is considered to be full-time attendance by the institution the student is attending;

NOTE: It is the responsibility of the *plan member* to furnish proof acceptable to the *program* documenting the full-time student status of a *dependent* child for each semester.

4. any *dependent* parent of an *employee* or of an *employee's* legal spouse, if living in the same household, was enrolled prior to July 1, 1984, and who is, or will be, claimed as a *dependent* on the *employee's* federal income tax return in the current tax year. The *program* will require an affidavit stating the covered *employee* intends to include the parent as a *dependent* on his federal income tax return for the current tax year. Continuation of coverage will be contingent upon the payment of a separate premium for this coverage.

Dependent Coverage benefits with respect to the *employee's dependents* only.

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

Durable Medical Equipment equipment which:

1. can withstand repeated use;
2. is primarily and customarily used to serve a medical purpose;
3. generally is not useful to a person in the absence of a illness or injury; and
4. is appropriate for use in the home. *Durable medical equipment* includes, but is not limited to, such items as wheelchairs, *hospital* beds, respirators, braces (non-dental) and other items that the *program* may determine to be *durable medical equipment*.

Emergency Room Services *hospital* services eligible for *reimbursement*, provided at a *hospital* emergency room and

billed by a *hospital*, and provided on an expeditious basis for *treatment* of unforeseen medical conditions which, if not immediately diagnosed and treated, could reasonably result in physical impairment or loss of life.

Employee a full-time *employee* as defined by a *participant employer* in accordance with state law. No person appointed on a *temporary appointment* will be considered an *employee*.

Employee Coverage benefits with respect to the *employee* only.

EPO an Exclusive Provider Organization. An *EPO* 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.

Family Unit Limit the dollar amount shown in the schedule of benefits has been incurred by three members of a family unit toward their *calendar year deductibles*. The *deductibles* of all additional members of that family unit will be considered satisfied for that year.

Fee Schedule the schedule of maximum allowable charges for professional or *hospital* services adopted and promulgated by the *board of trustees*.

Future Medical Recovery recovery from another plan of expenses contemplated to be necessary to complete medical *treatment* of the *covered person*.

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

Health Insurance Coverage benefits consisting of medical care (provided directly, through insurance or *reimbursement*, or otherwise) under any *hospital* or medical service policy or certificate, *hospital* or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described pursuant to the Health Insurance Portability and Accountability Act are not treated as benefits consisting of medical care.

Health Maintenance Organization (HMO) any 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 the Health Insurance Portability and Accountability Act of 1996 (USA Public Law 104-191).

Hospital an institution, which meets all the following requirements:

1. is currently a 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 or remedial training institution, or facilities primarily for the *treatment* of conduct and behavior disorders.

Incurred Date—the date upon which 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 pro rated share of the charge.

Inpatient Confinement—a *hospital* stay, which is equal to or exceeds 24 hours.

Lifetime Maximum Benefit—the total amount of benefits that will be paid under the *plan* for all eligible expenses incurred by a *covered person*.

Medically Necessary—a service or *treatment* which, in the judgement of the *program*:

1. is appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

2. is not primarily *custodial care*.

Medicare—the health insurance available through *Medicare* laws enacted by the Congress of the United States.

Network Pharmacy—a pharmacy, which 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—the application of any activity in which one engages 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.

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

Pain Rehabilitation Control and/or Therapy—any program designed to develop the individual's ability to control or tolerate chronic pain.

Participant Employer—a state entity, school board or a state political subdivision authorized by law to participate in the *program*.

Physical Therapy—the evaluation of physical status as related to functional abilities and *treatment* procedures as indicated by that evaluation.

Physician

1. *Physician* means the following persons, licensed to practice their respective professional skills by reason of statutory authority:

- a. doctor of medicine (M.D.);
- b. doctor of dental surgery (D.D.S.);
- c. doctor of dental medicine (D.M.D.);
- d. doctor of osteopathy (D.O.);
- e. doctor of podiatric medicine (D.P.M.);

f. doctor of chiropractic (D.C.);

g. doctor of optometry (O.D.);

h. psychologist meeting the requirements of the National Register of Health Service Providers in Psychology;

i. board certified social workers who are members of an approved clinical social work registry or employed by the United States, the State of Louisiana, or a Louisiana parish or municipality, if performing professional services as a part of the duties for which he is employed;

j. mental health counselors who are licensed by the state in which they practice;

k. substance abuse counselors who are licensed by the state in which they practice.

2. The term *physician* does not include social workers, who are not board certified; interns; residents; or fellows enrolled in a residency training program regardless of any other title by which he is designated or his position on the medical staff of a *hospital*. A senior resident, for example, who is referred to as an assistant attending surgeon or an associate *physician*, is considered a resident since the senior year of the residency is essential to completion of the training program. Charges made by a *physician*, who is on the faculty of a state medical school, or on the staff of a state *hospital*, will be considered a covered expense if the charges are made in connection with the *treatment* of a disease, illness, accident or injury covered under this *plan*, and if the *physician* would have charged a fee for the services in the absence of this provision.

3. It is the specific intent and purpose of the *program* to exclude *reimbursement* to the *covered person* for services rendered by social workers who are not board certified; and intern, resident, or fellow enrolled in a residency training program regardless of whether the intern, resident, or fellow was under supervision of a *physician* or regardless of the circumstances under which services were rendered.

4. The term *physician* does not include a practicing medical doctor in the capacity of supervising interns, residents, senior residents, or fellows enrolled in a training program, who does not personally perform a surgical procedure or provide medical *treatment* to the *covered person*.

Plan—coverage under this contract including *PPO* benefits, prescription drug benefits, mental health and substance abuse benefits and comprehensive medical benefits.

Plan Member—a *covered person* other than a *dependent*.

PPO—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—the State Employees Group Benefits *Program* as administered by the *board of trustees*.

Recovery monies paid to the *covered person* by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical or dental charges covered by the *program*.

Referee a hearing officer employed by the board, to whom an *appeal* may be referred for hearing.

Rehabilitation and Rehabilitation Therapy care concerned with the management of patients with impairments of function due to disease, illness, accident or injury.

Reimbursement repayment to the *program* for medical or dental benefits that it has paid toward care and *treatment* of the injury or sickness.

Rest Cure care provided in a sanitarium, nursing home or other facility and designed to provide *custodial care* and provide for the mental and physical well being of an individual.

Retiree an individual who was a covered *employee*, immediately prior to the date of retirement and who, upon retirement:

1. immediately received retirement benefits from an approved state or governmental agency defined benefit plan; or
2. was not eligible for participation in such a plan or had legally opted to not participate in such a plan; and
 - 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; or

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 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 State Employees Group Benefits Program;

4. *retiree* also means an individual who was a covered *employee* who 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 all *hospital* expenses necessary to maintain and sustain a *covered person* during a confinement, including but 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 charge.

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

Treatment includes consultations, examinations, diagnoses, and as well as medical services rendered in the care of a *covered person*.

Well-Adult Care 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, and billed by that *physician* with wellness procedure and diagnosis codes. All other health services coded with wellness procedures and diagnosis codes are excluded.

Well-Baby Care routine care to a well newborn infant from the date of birth until age 1. This includes routine physical examinations, active immunizations, check-ups, and office visits to a *physician* and billed by that *physician*, except for the *treatment* and/or diagnosis of a specific illness.

Well-Child Care routine physical examinations, active immunizations, check-ups and office visits to a *physician*, and billed by that *physician*, except for the *treatment* and/or diagnosis of a specific illness, from age 1 to age 16.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1820 (October 1999).

Chapter 7. Schedule of Benefits EPO

§701. Comprehensive Medical Benefits

A. Eligible expenses for professional medical services are reimbursed on a *fee schedule* of maximum allowable charges. All eligible expenses are determined in accordance with *plan* limitations and exclusions.

	Non-EPO Provider	EPO Provider
Lifetime maximum for all benefits except outpatient prescription drug benefits per person	\$2,000,000	
Lifetime maximum for all outpatient prescription drug benefits per person	\$250,000	

1. *Deductibles:*

	Non-EPO Provider	EPO Provider
Inpatient <i>deductible</i> per day, maximum of 5 days per admission (waived for admissions at <i>PPO hospitals</i>)	\$50	0
Emergency room charges for each visit unless the <i>covered person</i> is hospitalized immediately following emergency room <i>treatment</i> (prior to and in addition to <i>calendar year deductible</i>)	\$150	0
Professional and other eligible expenses, <i>employees</i> and <i>dependents</i> of <i>employees</i> , per person, per <i>calendar year</i> Family unit maximum (3 individual <i>deductibles</i>)		
Professional and other eligible expenses, <i>retirees</i> and <i>dependents</i> of <i>retirees</i> , per person, per <i>calendar year</i> Family unit maximum (3 individual <i>deductibles</i>)		
Professional and other eligible expenses, not otherwise subject to co-payment, per person, per <i>calendar year</i> Family unit maximum (3 individual <i>deductibles</i>)	\$300	0
	\$900	0

2.a. Percentage Payable after Satisfaction of Applicable *Deductibles*

	Non-EPO Provider	EPO Provider
Eligible expenses incurred at an EPO	N/A	100%
Eligible expenses incurred at a non-EPO	70%	N/A
Eligible expenses incurred when Medicare or other Group Health Plan is primary, and after Medicare reduction	80%	N/A
Eligible expenses in excess of \$10,000* per person per Calendar Year	100%	N/A
*Coinsurance threshold increase from \$5,000 to \$10,000 effective January 1, 2003		
<ul style="list-style-type: none"> Eligible expenses at EPO are based upon contracted rates. Eligible expenses at non-PPO 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 coinsurance threshold. 		

b. Member Co-Payments

	Non-EPO Provider	EPO Provider
Inpatient <i>Hospital Services</i>	N/A	\$100 per day up to \$300
Outpatient Services		
<i>Physician Services</i>	N/A	\$ 15/25 ¹
Physical/Occupational Therapy ²	N/A	\$ 15
Speech Therapy	N/A	\$ 15
Surgery	N/A	\$100
MRI/Cat Scan	N/A	\$ 50
Sonograms	N/A	\$ 25
Cardiac <i>Rehabilitation</i> (6-Month Limit)	N/A	\$ 15
<i>Emergency Room Services</i> (Waived If Admitted)	N/A	\$100

Pre-Natal and postpartum maternity (one-time co-payment to include <i>physician</i> delivery charge, all pre-natal, one postpartum visit)	N/A	\$ 90
Home health (limit 150 visits per <i>plan</i> year; requires prior approval through case management)	N/A	\$15 per visit
Note: services rendered by non-EPO providers are subject to <i>deductible</i> .		

3. Eligible *Hospital Expenses*

	Non-EPO Provider	EPO Provider
<i>Hospital room and board</i> not to exceed the average semi-private room rate	See % payable after <i>deductible</i>	100% after co-pay (\$100 per day up to \$300)
Intensive care unit not to exceed 2 1/2 times The <i>hospital's</i> average semi-private room rate	See % payable after <i>deductible</i>	100% after co-pay
Miscellaneous Expenses	See % payable after <i>deductible</i>	100% after co-pay

4. Prescription Drugs (Not subject to *deductible*)

<i>Network pharmacy</i>	Member pays 50 percent of drug costs at point of purchase.	
Maximum co-payment	\$40 per prescription dispensed	
Out-of-Pocket threshold	\$1000 per person, per <i>calendar year</i>	
Co-Pay after threshold is reached:		
Brand	\$15	
Generic	No co-pay	
<i>Plan</i> pays balance of eligible expense		
NOTE: Out-of-pocket thresholdC \$500 per person, for the period July 1-December 31, 2001		
Non- <i>Network pharmacy</i>	Member pays full drug costs at point of purchase.	
In-State	<i>Reimbursement</i> limited to 50% of amount payable by <i>plan</i> at <i>network pharmacy</i>	
Out-of-State	<i>Reimbursement</i> limited to 80% of amount payable by <i>plan</i> at <i>network pharmacy</i>	

B. Dental Surgery Benefit for Specified Procedure

Percentage payable (<i>deductible</i> waived)	100%
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C. Well Care

1. Well Baby

	Non-EPO Provider	EPO Provider
Birth to age 1 Call office visits for scheduled immunizations and screenings	See % payable after <i>deductible</i>	\$15 co-pay/office visit

2. Well Child

	Non-EPO Provider	EPO Provider
Age 1-2C3 office visits per year for scheduled immunizations and screenings	See % payable after <i>deductible</i>	\$15 co-pay/office visit
Age 3-15C1 office visit per year for scheduled immunizations and screenings	See % payable after <i>deductible</i>	\$15 co-pay/office visit

EMPLOYEE BENEFITS

3. Well Adult (No *deductible*; limited to a maximum benefit of \$200)

	Non-EPO Provider	EPO Provider
Age 16 to 39C1 physical every 3 years	70% of maximum	No co-pay
Age 40 to 49C1 physical every 2 years	70% of maximum	No co-pay
Age 50 and overC1 physical every year	70% of maximum	No co-pay

D. Pre-Natal and Postpartum Maternity. (\$90 one-time charge to include *physician* delivery Charge, all pre-natal, one post-partum visit)

E. *Durable Medical Equipment*

	Non-EPO Provider	EPO Provider
Lifetime maximum per covered person		\$50,000
Percentage payable	See % payable after <i>deductible</i>	20% co-pay; 100% coverage after \$50,000 eligible expense met for <i>calendar year</i>

F. - H. Reserved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees' Group Benefits Program, LR 25:1823 (October 1999), amended LR 26:487 (March 2000), LR 27:717 and 719 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1886 (November 2001), LR 28:476 (March 2002), LR 28:2342, 2343 (November 2002), repromulgated LR 28:2509 (December 2002).

§703. Mental Health and Substance Abuse

NOTE: Requires prior approval of services.

A. *Deductibles*

Annual per person (separate from comprehensive medical benefits <i>deductible</i>)	\$ 200
Inpatient (maximum 5 days; \$250 per stay)	\$ 50 per day

B. Benefits

Benefits
80% of the first \$5,000 of eligible expenses
100 % of eligible expenses over \$5,000 until the lifetime maximum for all <i>plan</i> benefits is reached
Up to a maximum of 45 inpatient days per person, per <i>calendar year</i>
Up to a maximum of 52 outpatient visits per person, per calendar year, inclusive of the intensive outpatient program

NOTE: Two days of partial hospitalization or two days of residential *treatment* center hospitalization may be traded for each inpatient day of *treatment* that is available under the 45-day *calendar year* maximum for inpatient *treatment*. A residential *treatment* center is a 24-hour mental health or substance abuse, non-acute care *treatment* setting for active *treatment* interventions directed at the amelioration of the specific impairments that led to admission. Partial hospitalization is a level of care where the patient remains in the *hospital* less than 24 hours. Expenses incurred for emergency services will only be reimbursed 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*.

¹The \$15 copay applies to primary care *physicians*. PCPs are limited to general practice, internal medicine, family practice, OB gyn, and pediatrician.

²Subject to Pre-Admission Certification (PAC) Guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1824 (October 1999).

Title 32 EMPLOYEE BENEFITS

Part VII. Public Employees Deferred Compensation

Chapter 1. Administration

§101. Definitions

Administrator or *Plan Administrator* C the person, persons or entity appointed by the Louisiana Deferred Compensation Commission to administer the Plan pursuant to LAC 71:VII.103.A, if any.

Age 50 or Older Catch-up C the deferred amount described pursuant to LAC 71:VII.303.C.

Beneficiary C the person, persons or entities designated by a participant pursuant to LAC 71:VII.301.A.5.

Commission C the Louisiana Deferred Compensation Commission, as established in accordance with R.S. 42:1302, which shall be comprised of the state treasurer, the commissioner of Administration, the commissioner of Insurance, the commissioner of Financial Institutions (or their designees), and three participant members (elected by the participants).

Compensation C all payments paid by the employer to an employee or independent contractor as remuneration for services rendered, including salaries and fees, and, to the extent permitted by Treasury regulations or other similar guidance, accrued vacation and sick leave pay.

Custodial Account C the account established with a bank or trust company meeting the provisions of *Internal Revenue Code (IRC)* ' 401(f), that the commission has elected to satisfy the trust requirement of IRC ' 457(g) by setting aside plan assets in a custodial account.

Custodian C the bank or trust company selected by the commission to hold Plan assets pursuant to IRC ' ' 457(g) and ' 401(f).

Deferred Compensation C the amount of compensation not yet earned, which the participant and the commission mutually agree, shall be deferred.

Employee C any individual, including an individual who is elected or appointed, providing personal services to the employer, provided, however, that an independent contractor shall not be treated as an employee.

Employer C the state of Louisiana. *Employer* shall also mean any political subdivision of the state and any agency or instrumentality of the state or of a political subdivision of the state that has selected this Plan as their eligible IRC ' 457 Deferred Compensation Plan.

Includible Compensation C (for purposes of the limitation set forth in LAC 71:VII.303.A), compensation for services performed for the employer as defined in IRC §457(e)(5).

Independent Contractor C an individual (not a corporation, partnership, or other entity), who is receiving compensation for services rendered to or on behalf of the employer in accordance with a contract between such individual and the employer.

Interest or Interest in Deferred Compensation C under the plan, the aggregate of:

1. a participant's deferred compensation for his or her entire period of participation in the Plan; and

2. the earnings or losses allocable to such amount. Such interest represents an accounting entry only and does not constitute an ownership interest, right or title in the assets so invested.

IRCC C the Internal Revenue Code of 1986, as amended, or any future United States Internal Revenue law. References herein to specific section numbers shall be deemed to include Treasury regulations thereunder and Internal Revenue Service guidance thereunder and to corresponding provisions of any future United States internal revenue law.

Investment Product C any form of investment designated by the commission for the purpose of receiving funds under the Plan.

Limited Catch-Up C the deferred amount described in LAC 71:VII.305.A.

Normal Retirement Age C

1. the age designated by a participant, which age shall be between:

a. the earliest date on which such participant is entitled to retire under the public retirement system of which that participant is a member without actuarial reduction in his or her benefit; and

b. age 70 1/2, provided, however, that if a participant continues in the employ of the employer beyond 70 1/2, *normal retirement age* means the age at which the participant severs employment;

2. if the participant is not a member of a defined benefit plan in any public retirement system, the participant's *normal retirement age* may not be earlier than age 50, and may not be later than age 70 1/2;

3. if a participant continues to be employed by employer after attaining age 70 1/2, not having previously elected an alternate *normal retirement age*, the participant's alternate *normal retirement age* shall not be later than the mandatory retirement age, if any, established by the employer, or the age at which the participant actually severs employment with the employer if the employer has no mandatory retirement age.

EMPLOYEE BENEFITS

Participant—An individual who is eligible to defer compensation under the Plan, and has executed an effective deferral authorization. *Participant* also includes an employee or independent contractor who has severance from employment but has not received a complete distribution of his or her interest in deferred compensation under the Plan.

Participation Agreement—the agreement executed and filed by an individual who is eligible to defer compensation under the Plan, and has executed an effective deferral authorization.

Pay Period—a regular accounting period designated by the employer for the purpose of measuring and paying compensation earned by an employee or independent contractor.

Plan—the State of Louisiana Public Employees Deferred Compensation Plan established by this document and any applicable amendment.

Plan Year—the calendar year.

Qualified Domestic Relations Order or *QDRO*—as specified in LAC 71:VII.1503.B.

Separation from Service or Separates from Service

1. with respect to an employee, the permanent severance of the employment relationship with the employer on account of such employee's:

- a. retirement;
- b. discharge by the employer;
- c. resignation;
- d. layoff; or
- e. in the case of an employee who is an appointed or elected officer, the earlier of:
 - i. the taking of the oath of office of such officer's successor; or
 - ii. the cessation of the receipt of compensation.

2. If an employee incurs a break in service for a period of less than 30 days or transfers among various Louisiana governmental entities, such break or transfer shall not be considered a *separation from service*.

3. With respect to an independent contractor, *separation from service* means that the expiration of all contracts pursuant to services performed for or on behalf of the employer.

Severance from Employment or Severs Employment

1. *severance* of the participant's employment with the employer. A participant shall be deemed to have severed employment with the employer for purposes of this Plan when both parties consider the employment relationship to have terminated and neither party anticipates any future employment of the participant by the employer. In the case of a participant who is an independent contractor, *severance from employment* shall be deemed to have occurred when:

a. the participant's contract for services has completely expired and terminated;

b. there is no foreseeable possibility that the employer shall renew the contract or enter into a new contract for services to be performed by the participant; and

c. it is not anticipated that the participant shall become an employee of the employer.

2. with respect to an employee, the permanent severance of the employment relationship with the employer on account of such employee's:

- a. retirement;
- b. discharge by the employer;
- c. resignation;
- d. layoff; or

e. in the case of an employee who is an appointed or elected officer, the earlier of:

- i. the taking of the oath of office of such officer's successor; or
- ii. the cessation of the receipt of compensation.

3. If an employee incurs a break in service for a period of less than 30 days or transfers among various Louisiana governmental entities, such break or transfer shall not be considered a severance from employment.

Total Amount Deferred—with respect to each participant, the sum of all compensation deferred under the Plan (plus investment gains and/or losses thereon, including amounts determined with reference to life insurance policies) calculated in accordance with the method designated in the participant's participation agreement(s) under which such compensation was deferred and any subsequent election(s) to change methods, less the amount of any expenses or distributions authorized by this Plan.

Trustee—the commission or such other person, persons or entity selected by the commission who agrees to act as *trustee*. This term also refers to the person holding the assets of any custodial account or holding any annuity contract described in LAC 71:VII.317.

Unforeseeable Emergency—severe financial hardship to a participant resulting from a sudden and unexpected illness or accident of the participant or of a dependent [as defined in IRC §152(a)] of the participant; loss of the participant's property due to casualty; or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant.

The need to send a participant's child to college or the desire to purchase a home shall not constitute an *unforeseeable emergency*. Whether a hardship constitutes an *unforeseeable emergency* under IRC ' 506 shall be determined in the sole discretion of the commission.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1962 (October 1998), amended LR 28:1494 (June 2002).

§103. Commission Authority

A. The commission shall have full power and authority to adopt rules or policies required to implement the Plan and to interpret, amend or repeal any such rule or policy. In addition, the commission shall have full power and authority to administer the Plan or to arrange for the administration of the Plan through appropriate contracts or agents in accordance with applicable state law. The power and authority of such agents shall be limited to the powers enumerated in the contractual agreements between the commission and such agents.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1963 (October 1998).

§105. Duties of Commission

A. The duties shall include:

1. appointing one (or more) attorney, accountant, actuary, custodian, record keeper or any other party needed to administer the Plan;

2. directing the trustee or custodian with respect to payments from assets held in the Plan;

3. communicating with employees regarding their participation and benefits under the Plan, including the administration of all claims procedures;

4. filing any returns and reports with the Internal Revenue Service or any other governmental agency;

5. reviewing and approving any financial reports, investment reviews, or other reports prepared by any party appointed under ' 105.A.1;

6. establishing a funding policy and investment objectives consistent with the purposes of the Plan;

7. construing and resolving any question of Plan interpretation. The commission's interpretation of Plan provisions (including eligibility and benefits under the Plan) is final;

8. appointing an emergency committee comprised of at least three individuals. Applications for a withdrawal of deferred compensation based on an unforeseeable emergency shall be approved or disapproved by such committee.

a. A participant shall furnish medical or other evidence to the emergency committee to establish and substantiate the existence of an unforeseeable emergency.

b. If an application for a withdrawal based on unforeseeable emergency is approved, the amount of the withdrawal shall be limited to the amount required to meet such emergency. Payment shall not be made to the extent such emergency is relieved:

i. through reimbursement or compensation by insurance or otherwise;

ii. by the liquidation of the participant's assets, provided the liquidation does not cause a financial hardship; or

iii. by the revocation of the participant's deferral authorization.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1963 (October 1998), amended LR 28:1495 (June 2002).

§107. Administrative Fees and Expenses

A. The commission may, in its sole discretion, use one or more of the following methods to meet the costs of administering the Plan. The commission may:

1. establish a reasonable monthly or annual administrative charge;

2. deduct an allocable portion of administrative costs from deferred compensation;

3. deduct an allocable portion of administrative costs from the income or earnings of investment products;

4. authorize any duly-appointed administrator to accept commissions from providers of investment products, provided, however, that the amount of such commissions may not exceed the amount of similar commissions paid to unrelated third parties;

5. deduct administrative costs from funds on deposit in financial institutions; and/or

6. deduct any other reasonable fee or commission required to defray the costs of administering the Plan.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1963 (October 1998).

§109. Actions of Administrator

A. Every action taken by the commission shall be presumed to be a fair and reasonable exercise of the authority vested in or the duties imposed upon it. The commission shall be deemed to have exercised reasonable care, diligence and prudence and to have acted impartially as to all affected persons, unless the contrary is proven by affirmative evidence. No member, if a participant of the commission or a committee, shall make any determination (other than a policy decision which affects all participants) similarly situated with respect to his or her specific interest in deferred compensation under the Plan. The commission shall not be liable for amounts of compensation deferred by participants or for other amounts payable under the Plan.

AUTHORITY NOTE: Promulgated in accordance with IRC ' 457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998).

§111. Delegation

A. Subject to any applicable laws and any approvals required by the employer, the commission may delegate any or all of its powers and duties hereunder to another person, persons, or entity, and may pay reasonable compensation for such services as an administrative expense of the Plan, to the extent such compensation is not otherwise paid.

AUTHORITY NOTE: Promulgated in accordance with IRC '457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998).

Chapter 3. Plan Participation, Options and Requirements

§301. Enrollment in the Plan

A. The following rules apply to compensation deferred under the Plan.

1. A participant may not defer any compensation unless a deferral authorization providing for such deferral has been completed by the participant and accepted by the commission prior to the beginning of such payroll period. With respect to a new employee, compensation will be deferred in the payroll period during which a participant first becomes an employee if a deferral authorization providing for such deferral is executed on or before the first day on which the participant becomes an employee. Any prior employee who was a participant in the Plan and is rehired by employer may resume participation in the Plan by entering into a participation agreement. Unless distributions from the Plan have begun due to that prior severance from employment, however, any deferred commencement date elected by such employee with respect to those prior Plan assets shall be null and void.

2. In signing the Participation Agreement, the participant elects to participate in this Plan and consents to the deferral by the employer of the amount specified in the Participation Agreement from the participant's gross compensation for each pay period. Such deferral shall continue in effect until modified, disallowed or revoked in accordance with the terms of this Plan.

3. The minimum amount of compensation deferred under a deferral authorization shall be no less than \$20 each month; provided, however, that such minimum deferral shall not apply to a participant whose deferral authorization (or similar form) in effect on October 1, 1984, permitted a smaller deferral, or to a participant who elects to defer not less than 7.5 percent of compensation (voluntary and/or involuntary contributions) in lieu of Social Security coverage (§11332 of the Social Security Act and IRC §3121). The employer retains the right to establish minimum deferral amounts per pay period and to limit the number and/or timing of enrollments into the Plan in the Participation Agreement.

4. Notwithstanding LAC 71:VII.301.A.1, to the extent permitted by applicable law, the administrator may establish procedures whereby each employee becomes a participant in the Plan and, as a term or condition of employment, elects to participate in the Plan and consents to the deferral by the employer of a specified amount for any payroll period for which a participation agreement is not in effect. In the event such procedures are in place, a participant may elect to defer a different amount of compensation per payroll period, including zero, by entering into a participation agreement.

5. Beneficiary. Each participant shall initially designate in the participation agreement a beneficiary or beneficiaries to receive any amounts, which may be distributed in the event of the death of the participant prior to the complete distribution of benefits. A participant may change the designation of beneficiaries at any time by filing with the commission a written notice on a form approved by the commission. If no such designation is in effect at the time of participant's death, or if the designated beneficiary does not survive the participant by 30 days, his beneficiary shall be his surviving spouse, if any, and then his estate

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998), amended LR 28:1495 (June 2002).

§303. Deferral Limitations

A. Except as provided in LAC 71:VII.305.A.1-2.a-b, the maximum that may be deferred under the Plan for any taxable year of a participant shall not exceed the lesser of:

1. the applicable dollar amount in effect for the year, as adjusted for the calendar year in accordance with IRC §457(e)(15); or

2. One hundred percent of the participant's includible compensation, each reduced by any amount specified in Subsection B of this §303 that taxable year.

B. The deferral limitation shall be reduced by any amount excludable from the participant's gross income attributable to elective deferrals to another eligible deferred compensation plan described in IRC §457(b).

C. A participant who attains age 50 or older by the end of a Plan year and who does not utilize the limited catch-up for such Plan year may make a deferral in excess of the limitation specified in Subsection A.1-2 of this §303, up to the amount specified in and subject to any other requirements under IRC §414(v).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1964 (October 1998), amended LR 28:1496 (June 2002).

§305. Limited Catch-Up

A. For one or more of the participant's last three taxable years ending before the taxable year in which normal retirement age under the Plan is attained, the maximum deferral shall be the lesser of:

1. twice the otherwise applicable dollar limit under IRC §457(e)(15) for that taxable year; reduced by any applicable amount specified in LAC 71:VII.303.B; or

2. the sum of:

a. the limitations established for purposes of §303.A of these rules, for such taxable year (determined without regard to this §305); also

b. so much of the limitation established under §303.A of the Plan or established in accordance with IRC §457(b)(2) and the regulations thereunder under an eligible deferred compensation plan sponsored by an entity other than the employer and located in the same state for prior taxable years (beginning after December 31, 1978 and during all or any portion of which the participant was eligible to participate in this Plan) and has not theretofore been used under §§303.A or 305.A hereof or under such other plan (taking into account the limitations under and participation in other eligible deferred compensation plans in accordance with the *Internal Revenue Code*); provided, however, that this §305 shall not apply with respect to any participant who has previously utilized, in whole or in part, the limited catch-up under this Plan or under any other eligible deferred compensation plan (within the meaning of IRC §457 and the regulations thereof).

B. If a participant is not a member of a defined benefit plan in any public retirement system, normal retirement age may not be earlier than age 50, and may not be later than age 70 1/2.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002).

§307. Participant Modification of Deferral

A. The participant shall be entitled to modify the amount (or percentage) of deferred compensation once each enrollment period with respect to compensation payable no earlier than the payroll period after such modification is entered into by the participant and accepted by the commission. Notwithstanding the above, if a negative election procedure has been implemented pursuant to §301.A.4 of this Chapter, a participant may enter into or modify a participation agreement at any time to provide for no deferral.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002).

§309. Employer Modification of Deferral

A. The commission shall have the right to modify or disallow the periodic deferral of compensation elected by the participant:

1. in excess of the limitations stated in LAC 71:VII.303.A and 305.A;

2. in excess of the participant's net compensation for any pay period;

3. upon any change in the length of pay period utilized by employer. In such case the periodic deferral shall be adjusted so that approximately the same percentage of pay shall be deferred on an annual basis;

4. in order to round down periodic deferrals to the nearest whole cent amount;

5. to reduce the future deferrals in the event that the amount actually deferred for any pay period exceeds, for any reason whatsoever, the amount elected by the participant. In the alternative, such amount of excess deferral may be refunded to the participant. No adjustment in future deferrals shall be made if a periodic deferral is missed or is less than the amount elected, for any reason whatsoever; or

6. if the deferral elected for any pay period is less than the minimum amount specified in LAC 71:VII.301.A.3;

B. And to the extent permitted by and in accordance with the Internal Revenue Code, the employer or administrator may distribute the amount of a participant's deferral in excess of the distribution limitations stated in LAC 71:VII.301, 303, 305, 307 and 309 notwithstanding the limitations of LAC 71:VII.701.A; provided, however, that the employer and the commission shall have no liability to any participant or beneficiary with respect to the exercise of, or the failure to exercise, the authority provided in this LAC 71:VII.309.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002).

§311. Revocation

A. A participant may, at any time, revoke his or her deferral authorization by notifying the commission, in writing, on forms acceptable to the commission. Upon the acceptance of such notification, deferrals under the plan shall cease no later than the commencement of the first pay period beginning at least 30 days after acceptance; provided, however, that the commission shall not be responsible for any delay which occurs despite its good faith efforts. In no event shall the revocation of a participant's deferral authorization permit a distribution of deferred compensation, except as provided in §701.A of these rules, and shall be subject to the terms and provisions of the affected investment.

B. A participant's request for a distribution in the event of an unforeseeable emergency shall in addition be treated as a request for revocation of deferrals as of a date determined by the commission.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1965 (October 1998), amended LR 28:1496 (June 2002).

§313. Re-Enrollment

A. A participant who revokes the participation agreement as set forth in §311.A above may execute a new participation agreement to defer compensation payable no earlier than the payroll period after such new participation agreement is executed by the participant and accepted by the commission.

B. A former participant who is rehired after retirement may rejoin the Plan as an active participant unless ineligible to participate under other Plan provisions.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998), amended LR 28:1496 (June 2002).

§315. Multiple Plans

A. Should a participant participate in more than one deferred compensation plan governed by IRC §457, the limitations set forth in LAC 71:VII.303 and 305 shall apply to all such plans considered together. For purposes of LAC 71:VII.303 and 305, compensation deferred shall be taken into account at its value in the later of the plan year in which deferred or the plan year in which such compensation is no longer subject to a substantial risk of forfeiture (within the meaning of IRC §457).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

§317. Custody of Plan Assets

A. All amounts of compensation deferred under the Plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property or rights shall be held for the exclusive benefit of participants and their beneficiaries. The trust requirement of IRC §457(g) shall be satisfied as Plan assets and shall be set aside as follows.

1. Plan assets shall be set aside in one or more annuity contracts described in IRC §401(f). The owner of the annuity contract is the "deemed trustee" of the assets invested under the contract for purposes of IRC §457(g).

2. Plan assets shall be set aside in one or more custodial accounts described in IRC §401(f). The bank or trust company shall be the custodian and "deemed trustee" for purposes of IRC §457(g) and shall accept such appointment by executing same. The commission and custodian must enter into a separate written custody agreement.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

§319. Qualified Military Service

A. Notwithstanding any provision of this Plan to the contrary, contributions and benefits with respect to qualified military service shall be provided in accordance with IRC §414(u).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

Chapter 5. Investments**§501. Investment Options**

A. The commission shall in its sole discretion select certain investment options to be used to determine income to be accrued on deferrals. These investment options may include specified life insurance policies, annuity contracts, or investment media issued by an insurance company. In any event, it shall be the sole responsibility of the commission to ensure that all investment options offered under the Plan are appropriate and in compliance with any and all state laws pertaining to such investments.

B. The commission shall have the right to direct the trustee with respect to investments of the Plan assets, may appoint an investment manager to direct investments, or may give the trustee sole investment management responsibility. Any investment directive shall be made in writing by the commission or investment manager. In the absence of such written directive, the trustee shall automatically invest the available cash in its discretion in an appropriate interim investment until specific investment directions are received. Such instructions regarding the delegation of investment responsibility shall remain in force until revoked or amended in writing. The trustee shall not be responsible for the propriety of any directed investment made and shall not be required to consult with or advise the commission regarding the investment quality of any directed investment held hereunder.

C. The commission may, from time to time, change the investment options under the Plan. If the commission eliminates a certain investment option, all participants who had chosen that investment shall select another option. If no new option is selected by the participant, money remaining in the eliminated investment option shall be moved at the direction of the commission. The participants shall have no right to require the commission to select or retain any investment option. To the extent permitted by and subject to any rules or procedures adopted by the administrator, a participant may, from time to time, change his choice of investment option. Any change with respect to investment options made by the commission or a participant, however, shall be subject to the terms and conditions (including any rules or procedural requirements) of the affected investment options and may affect only income to be accrued after that change.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

§503. Participant Investment Direction

A. Participants shall have the option to direct the investment of their personal contributions and their share of any employer contributions among alternative investment

options established as part of the overall Trust, unless otherwise specified by the employer. Such investment options shall be under the full control of the trustee. A participant's right to direct the investment of any contribution shall apply only to making selections among the options made available under the Plan.

B. Each participant shall designate on his or her Participation Agreement the investment that shall be used to determine the income to be accrued on amounts deferred. If the investment chosen by the participant experiences a gain, the participant's benefits under the Plan likewise shall reflect income for that period. If the investment chosen by a participant experiences a loss, or if charges are made under such investment, the participant's benefits under the Plan likewise shall reflect such loss or charge for that period.

C. Neither the commission, the administrator, the trustee nor any other person shall be liable for any losses incurred by virtue of following the participant's directions or with any reasonable administrative delay in implementing such directions.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1966 (October 1998).

§505. Participant Accounts

A. The commission shall maintain or cause to be maintained one or more individual deferred compensation ledger account or similar individual account(s) for each participant. Such accounts shall include separate accounts, as necessary, for IRC §457 Deferred Compensation, IRC §457 rollovers, IRA rollovers, other qualified plan and IRC §403(b) plan rollovers, and such other accounts as may be appropriate from time to time for plan administration. At regular intervals established by the commission, each participant's account shall be:

1. credited with the amount of any deferred compensation paid into the Plan;
2. debited with any applicable administrative or investment expense, allocated on a reasonable and consistent basis;
3. credited or debited with investment gain or loss, as appropriate; and
4. debited with the amount of any distribution.

B. At least once per calendar quarter, each participant shall be notified in writing of his/her total amount deferred.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002).

§507. Distributions from the Plan

A. The payment of benefits in accordance with the terms of the Plan may be made by the trustee, or by any custodian or other person so authorized by the commission to make

such distribution. Neither the commission, the trustee nor any other person shall be liable with respect to any distribution from the Plan made at the direction of the employer or a person authorized by the employer to give disbursement direction.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998).

Chapter 7. Distributions

§701. Conditions for Distributions

A. Payments from the participants §457 Deferred Compensation Plan account to the participant or beneficiary shall not be made, or made available, earlier than:

1. the participant's severance from employment pursuant to LAC 71:VII.703.A or death; or
2. the participant's account meets all of the requirements for an in-service *de minimus* distribution pursuant to LAC 71:VII.705.A and B; or
3. the participant incurs an approved unforeseeable emergency pursuant to LAC 71:VII.709.A; or
4. the participant transfers an amount to a defined benefit governmental plan pursuant to LAC 71:VII.705.C; or
5. April 1 of the calendar year following the calendar year in which the participant attains age 70 1/2.

B. Payments from a participant's rollover account(s) may be made at any time.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002).

§703. Severance from Employment

A. Distributions to a participant shall commence following the date in which the participant severs employment, in a form and manner determined pursuant to LAC 71:VII.713.A, 715.A and 717.A.

B. Upon notice to participants, and subject to LAC 71:VII.701.A., 703.B and 721.A, the administrator may establish procedures under which a participant whose total §457 deferred compensation account balance is less than an amount specified by the administrator (not in excess of \$5,000 or other applicable limit under the Internal Revenue Code) will receive a lump sum distribution on the first regular distribution commencement date (as the employer or administrator may establish from time to time) following the participant's severance from employment, notwithstanding any election made by the participant pursuant to LAC 71:VII.721.A.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

EMPLOYEE BENEFITS

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002).

§705. In-Service Distributions

A. Voluntary In-Service Distribution of *De Minimis* Accounts. A participant who is an active employee shall receive a distribution of the total amount payable to the participant under the Plan if the following requirements are met:

1. the portion of the total amount payable to the participant under the Plan does not exceed an amount specified from time to time by the commission (not in excess of \$5,000 or other applicable limit under the *Internal Revenue Code*);

2. the participant has not previously received an in-service distribution of the total amount payable to the participant under the Plan;

3. no amount has been deferred under the Plan with respect to the participant during the two-year period ending on the date of the in-service distribution; and

4. the participant elects to receive the distribution.

B. Involuntary In-Service Distribution of *De Minimis* Accounts. Upon notice to participants, and subject to LAC 71:VII.721.A, the commission may establish procedures under which the Plan shall distribute the total amount payable under the Plan to a participant who is an active employee if the following requirements are met:

1. the portion of the total amount payable to the participant under the Plan does not exceed an amount specified from time to time by the commission (not in excess of \$5,000 or other applicable limit under the *Internal Revenue Code*);

2. the participant has not previously received an in-service distribution of the total amount payable to the participant under the Plan; and

3. no amount has been deferred under the Plan with respect to the participant during the two-year period ending on the date of the in-service distribution.

C. Purchase of Defined Benefit Plan Service Credit

1. If a participant is also a participant in a defined benefit governmental plan (as defined in IRC §414(d)), such participant may request the commission to transfer amounts from his or her account for:

a. the purchase of permissive service credit (as defined in IRC §415(n)(3)(A)) under such plan; or

b. a repayment to which IRC §415 does not apply by reason of IRC §415(k)(3).

2. Such transfer requests shall be granted in the sole discretion of the commission, and if granted, shall be made directly to the defined benefit governmental plan.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002).

§707. Deferred Commencement Date at Separation from Service

A. Following the date in which the participant severs employment, the participant may select a deferred commencement date for all or a portion of the participant's account balance. If the participant elects to defer the entire account balance, the future commencement date may not be later than April 1 of the calendar year following the calendar year in which the participant attains age 70 1/2.

B. If the participant is an independent contractor:

1. in no event shall distributions commence prior to the conclusion of the 12-month period beginning on the date on which all such participant's contracts to provide services to or on behalf of the employer expire; and

2. in no event shall a distribution payable to such participant pursuant to §703.A of these rules commence if, prior to the conclusion of the 12-month period, the participant performs services for the employer as an employee or independent contractor.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1498 (June 2002).

§709. Unforeseeable Emergency

A. If a participant has incurred a genuine unforeseeable emergency and no other resources of financial relief are available, the commission may grant, in its sole discretion, a participant's request for a payment from the participant's account. Any payment made under this provision shall be in a lump sum.

1. The commission shall have the right to request and review all pertinent information necessary to assure that hardship withdrawal requests are consistent with the provisions of IRC §457.

2. In no event, however, shall an unforeseeable emergency distribution be made if such hardship may be relieved:

a. through reimbursement or compensation by insurance or otherwise;

b. by liquidation of the participant's assets, to the extent the liquidation of the participant's assets would not itself cause a severe financial hardship; or

c. by cessation of deferrals under this Plan.

3. The amount of any financial hardship benefit shall not exceed the lesser of:

a. the amount reasonably necessary, as determined by the commission, to satisfy the hardship; or

b. the amount of the participant's account.

4. Payment of a financial hardship distribution shall result in mandatory suspension of deferrals for a minimum of six months from the date of payment (or such other period as mandated in Treasury regulations).

5. Currently, the following events are not considered unforeseeable emergencies under the Plan:

- a. enrollment of a child in college;
- b. purchase of a house;
- c. purchase or repair of an automobile;
- d. repayment of loans;
- e. payment of income taxes, back taxes, or fines associated with back taxes;
- f. unpaid expenses including rent, utility bills, mortgage payments, or medical bills;
- g. marital separation or divorce; or
- h. bankruptcy (except when bankruptcy resulted directly and solely from illness or casualty loss).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1968 (October 1998), amended LR 28:1498 (June 2002).

§711. Death Benefits

A. Upon the participant's death, the participant's remaining account balance(s) will be distributed to the beneficiary commencing after the administrator receives satisfactory proof of the participant's death (or on the first regular distribution commencement date thereafter as the employer or administrator may establish from time to time), unless prior to such date the beneficiary elects a deferred commencement date, in a form and manner determined pursuant to LAC 71:VII.713.A and 717.A.

B. If there are two or more beneficiaries, the provisions of this §711 and of §717.A of these rules shall be applied to each beneficiary separately with respect to each beneficiary's share in the participant's account.

C. If the beneficiary dies after beginning to receive benefits but before the entire account balance has been distributed, the remaining account balance shall be paid to the estate of the beneficiary in a lump sum.

D. Under no circumstances shall the commission be liable to the beneficiary for the amount of any payment made in the name of the participant before the commission receives satisfactory proof of the participant's death.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1968 (October 1998), amended LR 28:1498 (June 2002).

§713. Payment Options

A. A participant's or beneficiary's election of a payment option must be made at least 30 days prior to the date that the payment of benefits is to commence. If a timely election of a payment option is not made, benefits shall be paid in accordance with §715.A of this Chapter 7. Subject to applicable law and the other provisions of this Plan, distributions may be made in accordance with one of the following payment options:

1. a single lump-sum payment;
2. installment payments for a period of years (payable on a monthly, quarterly, semiannual, or annual basis) which extends no longer than the life expectancy of the participant or beneficiary as permitted under the requirements of IRC §401(a)(9);
3. installment payments for a period of years (payable on a monthly, quarterly, semiannual, or annual basis) automatically adjusted for cost-of-living increases based on the rise in the *Consumer Price Index for All Urban Consumers* (CPI-U) from the third quarter of the last year in which a cost-of-living increase was provided to the third quarter of the current year. Any increase shall be made in periodic payment checks beginning the following January;
4. partial lump-sum payment of a designated amount, with the balance payable in installment payments for a period of years, as described in Subsection A of this §713;
5. annuity payments (payable on a monthly, quarterly, or annual basis) for the lifetime of the participant or for the lifetime of the participant and beneficiary in compliance with IRC §401(a)(9);
6. such other forms of installment payments as may be approved by the commission consistent with the requirements of IRC §401(a)(9).

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1968 (October 1998), amended LR 28:1498 (June 2002).

§715. Default Distribution Option

A. In the absence of an effective election by the participant, beneficiary or other payee, as applicable, as to the commencement and/or form of benefits, distributions shall be made in accordance with the applicable requirements of IRC §§401(a)(9) and 457(d), and proposed or final Treasury regulations thereunder.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002).

§717. Limitations on Distribution Options

A. No distribution option may be selected by a participant or beneficiary under this §717 unless it satisfies the requirements of IRC §§401(a)(9) and 457(d) and proposed or final Treasury regulations thereunder.

B. If installment payments are designated as the method of distribution, the minimum distribution shall be no less than \$100 per check and the payments made annually must be no less than \$600.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002).

§719. Taxation of Distributions

A. To the extent required by law, income and other taxes shall be withheld from each benefit payment, and payments shall be reported to the appropriate governmental agency or agencies.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002).

§721. Transfers and Rollovers

A. Transfers to the Plan. If the participant was formerly a participant in an eligible deferred compensation plan maintained by another employer, and if such plan permits the direct transfer of the participant's interest therein to the Plan, then the Plan shall accept assets representing the value of such interest; provided, however, that the participant has separated from service with that former employer and become an employee of employer. Such amounts shall be held, accounted for, administered and otherwise treated in the same manner as compensation deferred by the participant except that such amounts shall not be considered compensation deferred under the Plan in the taxable year of such transfer in determining the maximum deferral under LAC 71:VII.303.A.1-2. The commission may require such documentation from the predecessor plan, as it deems necessary to confirm that such plan is an eligible deferred compensation plan within the meaning of IRC §457, and to assure that transfers are provided under such plan. The commission may refuse to accept a transfer in the form of assets other than cash, unless the commission agrees to hold such other assets under the Plan.

B. In-Service Transfers from the Plan. If a participant separates from service prior to his or her required beginning date, and becomes a participant in an eligible deferred compensation plan of another governmental employer, and provided that payments under this Plan have not begun, such participant may request a transfer of his or her account to the eligible deferred compensation plan of the other employer. Requests for such transfers must be made in writing to the commission and shall be granted in the sole discretion of the commission. If an amount is to be transferred pursuant to

this provision, the commission shall transfer such amount directly to the eligible deferred compensation plan of the other employer. Amounts transferred to another eligible deferred compensation plan shall be treated as distributed from this Plan and this Plan shall have no further responsibility to the participant or any beneficiary with respect to the amount transferred.

C. Rollovers to the Plan

1. The Plan shall accept a rollover contribution on behalf of a Participant or Employee who may become a participant. A *rollover contribution*, for purposes of this Subsection, is an eligible rollover contribution (as defined in IRC §402(f)(2)) from any:

- a. plan qualified under IRC §401(a) or 403(a);
- b. tax-sheltered annuity or custodial account described in IRC §403(b);
- c. individual retirement account or annuity described in IRC §408;
- d. eligible deferred compensation plan described in IRC §457(b).

2. Prior to accepting any rollover contribution, the commission may require that the participant or employee establish that the amount to be rolled over to the Plan is a valid rollover within the meaning of the Internal Revenue Code. A participant's rollover contribution shall be held in a separate rollover account or accounts, as the commission shall determine from time to time.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002).

§723. Eligible Rollover Distributions

A. General. Notwithstanding any provision of the Plan to the contrary that would otherwise limit a distributee's election under this §723, a distributee may elect, at the time and in the manner prescribed by the employer, to have any portion of an eligible rollover distribution paid directly to an eligible retirement plan specified by the distributee in a direct rollover.

B. Definitions. For purposes of this §723, the following definitions shall apply:

Eligible Rollover Distribution Can an eligible rollover distribution is any distribution of all or any portion of the balance to the credit of the distributee, except that an eligible rollover distribution does not include any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the distributee's designated beneficiary, or for:

- a. a specified period of 10 years or more;
- b. any distribution to the extent such distribution is required under IRC §401(a)(9);

c. any distribution that is a deemed distribution under the provisions of IRC §72(p);

d. the portion of any distribution that is not includable in gross income; and any hardship distribution or distribution on account of unforeseeable emergency.

Eligible Retirement Plan Can an eligible retirement plan is an individual retirement account described in IRC §408(a), an individual retirement annuity described in IRC §408(b), an annuity plan described in IRC §403(a) that accepts the distributee's eligible rollover distribution, a qualified trust described in IRC §401(a) (including §401(k)) that accepts the distributee's eligible rollover distribution, a tax-sheltered annuity described in IRC §403(b) that accepts the distributee's eligible rollover distribution, or another eligible deferred compensation plan described in IRC §457(b) that accepts the distributee's eligible rollover distribution. However, in the case of an eligible rollover distribution to the surviving spouse, an eligible retirement plan is an individual retirement account or individual retirement annuity.

Distributee C includes an employee or former employee, the employee's or former employee's surviving spouse and the employee's or former employee's spouse or former spouse who is the alternate payee under a Qualified Domestic Relations Order, as defined in IRC §414(p), are distributees with regard to the interest of the spouse or former spouse.

Direct Rollover Ca payment by the Plan to the eligible retirement plan specified by the distributee.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969 (October 1998), amended LR 28:1499 (June 2002).

§725. Elections

A. Elections under this Chapter 7 shall be made in such form and manner as the commission may specify from time to time. To the extent permitted by and in accordance with the *Internal Revenue Code*, any irrevocable elections as to the form or timing of distributions executed prior to January 1, 2002, are hereby revoked.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1500 (June 2002).

§727. Practices and Procedures

A. The commission may adopt practices and procedures applicable to existing and new distribution elections.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002).

Chapter 9. Leave of Absence

§901. Paid and Unpaid Leave of Absence

A. Paid Leave of Absence. If a participant is on an approved leave of absence from the employer with compensation, or on approved leave of absence without compensation that does not constitute a severance from employment within the meaning of IRC §402(d)(4)(A)(iii) which under the employer's current practices is generally a leave of absence without compensation for a period of one year or less, said participant's participation in the Plan may continue.

B. Unpaid Leave of Absence. If a participant is on an approved leave of absence without compensation and such leave of absence continues to such an extent that it becomes a severance from employment within the meaning of IRC §402(e)(4)(A)(iii), said participant shall have severed employment with the employer for purposes of this Plan. Upon termination of leave without pay and return to active status, the participant may execute a new participation agreement to be effective when permitted by LAC 71:VII.313.B of the Plan.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), LR 28:1500 (June 2002).

Chapter 11. Participant Loans

§1101. Authorization of Loans

A. The commission may direct the administrator to make loans to participants on or after the effective date of Treasury regulations or other guidance under IRC §457 and to the extent allowable under and in accordance with IRC §457. Such loans shall be made on the application of the participant in a form approved by the administrator and on such terms and conditions as are set forth in this Chapter 11, provided, however, that the administrator may adopt rules or procedures specifying different loan terms and conditions, if necessary or desirable, to comply with or conform to such Treasury regulations or other guidance and other applicable law.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1500 (June 2002).

§1103. Maximum Loan Amount

A. In no event shall any loan made to a participant be in an amount which shall cause the outstanding aggregate balance of all loans made to such participant under this Plan exceed the lesser of:

1. \$50,000, reduced by the excess (if any) of:

a. the highest outstanding balance of loans from the Plan to the participant during the one-year period ending on the day before the date on which the loan is made;

b. over the outstanding balance of loans from the Plan to the participant or the beneficiary on the date on which the loan is made; or

2. one-half of the participant's total amount deferred.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1500 (June 2002).

§1105. Repayment of Loan

A. Each loan shall mature and be payable, in full and with interest, within five years from the date such loan is made, unless:

1. the loan is used to acquire any dwelling unit that within a reasonable time (determined at the time the loan is made) will be used as the principal residence of the participant; or

2. loan repayments are, at the employer's election, suspended as permitted by IRC §414(u)(4) (with respect to qualified military service).

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002).

§1107. Loan Terms and Conditions

A. In addition to such rules as the administrator may adopt, which rules are hereby incorporated into this Plan by reference, all loans to participants shall comply with the following terms and conditions.

1. Loans shall be available to all participants on a reasonably equivalent basis.

2. Loans shall bear interest at a reasonable rate to be fixed by the administrator based on interest rates currently being charged by commercial lenders for similar loans. The administrator shall not discriminate among participants in the matter of interest rates, but loans granted at different times may bear different interest rates based on prevailing rates at the time.

3. Each loan shall be made against collateral, including the assignment of no more than one-half of the present value of the participant's total amount deferred as security for the aggregate amount of all loans made to such participant, supported by the participant's collateral promissory note for the amount of the loan, including interest.

4. Loan repayments must be made by payroll deduction. In all events, payments of principal and interest must be made at least quarterly and such payments shall be sufficient to amortize the principal and interest payable pursuant to the loan on a substantially level basis.

5. A loan to a participant or beneficiary shall be considered a directed investment option for such participant's account balance.

6. No distribution shall be made to any participant, or to a beneficiary of any such participant, unless and until all unpaid loans, including accrued interest thereon, have been satisfied. If a participant terminates employment with the employer for any reason, the outstanding balance of all loans made to him shall become fully payable and, if not paid within 30 days, any unpaid balance shall be deducted from any benefit payable to the participant or his beneficiary. In the event of default in repayment of a loan or the bankruptcy of a participant who has received a loan, the note will become immediately due and payable, foreclosure on the note and attachment of security will occur, the amount of the outstanding balance of the loan will be treated as a distribution to the participant, and the defaulting participant's accumulated deferrals shall be reduced by the amount of the outstanding balance of the loan (or so much thereof as may be treated as a distribution without violating the requirements of the *Internal Revenue Code*).

7. The loan program under the Plan shall be administered by the administrator in a uniform and nondiscriminatory manner. The administrator shall establish procedures for loans, including procedures for applying for loans, guidelines governing the basis on which loans shall be approved, procedures for determining the appropriate interest rate, the types of collateral which shall be accepted as security, any limitations on the types and amount of loans offered, loan fees and the events which shall constitute default and actions to be taken to collect loans in default.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1500 (June 2002).

Chapter 13. Plan Amendment or Termination

§1301. Termination

A. The commission may at any time terminate this Plan; provided, however, that no termination shall affect the amount of benefits, which at the time of such termination shall have accrued for participants or beneficiaries. Such accrued benefits shall include any compensation deferred before the time of the termination and income thereon accrued to the date of the termination.

B. Upon such termination, each participant in the Plan shall be deemed to have revoked his agreement to defer future compensation as provided in LAC 71:VII.311.A as of the date of such termination. Each participant's full compensation on a non-deferred basis shall be restored.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1501 (June 2002).

§1303. Amendments to the Plan

A. The commission may also amend the provisions of this Plan at any time; provided, however, that no amendment

shall affect the amount of benefits which at the time of such amendment shall have accrued for participants or beneficiaries, to the extent of compensation deferred before the time of the amendment and income thereon accrued to the date of the amendment, calculated in accordance with LAC 71:VII.505.A and the terms and conditions of the investment options hereunder; and provided further, that no amendment shall affect the duties and responsibilities of the trustee unless executed by the trustee.

B. Copies of Amendments. The administrator shall provide a copy of any plan amendment to any trustee or custodian and to the issuers of any investment options.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1970 (October 1998), amended LR 28:1501 (June 2002).

Chapter 15. Taxes, Nonassignability and Disclaimer

§1501. Tax Treatment of Amounts Deferred

A. It is intended that pursuant to IRC §457, the amount of deferred compensation shall not be considered current compensation for purposes of federal and state income taxation. This rule shall also apply to state income taxation unless applicable state laws provide otherwise. Such amounts shall, however, be included as compensation to the extent required under the Federal Insurance Contributions Act (FICA). Payments under this Plan shall supplement retirement and death benefits payable under the employer's group insurance and retirement plans, if any.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1971 (October 1998), amended LR 28:1501 (June 2002).

§1503. Nonassignability

A. It is agreed that neither the participant, nor any beneficiary, nor any other designee shall have any right to commute, sell, assign, transfer, or otherwise convey the right to receive any payments hereunder, which payments and right thereto are expressly declared to be nonassignable and nontransferable; and in the event of attempt to assign or transfer, the commission shall have no further liability hereunder, nor shall any unpaid amounts be subject to attachment, garnishment or execution, or be transferable by operation of law in event of bankruptcy, or insolvency, except to the extent otherwise required by law.

B. Qualified Domestic Relations Orders approved by the commission shall be administered as follows.

1.a. To the extent required under a final judgment, decree, or order made pursuant to a state domestic relations law, herein referred to as a Qualified Domestic Relations Order (QDRO) which is duly filed upon the commission, any portion of a participant's account may be paid or set aside for payment to an alternate payee.

NOTE: For purposes of this §1503, an alternate payee is a person or persons designated by a domestic relations order who may be a spouse, former spouse, or a child of the participant.

b. Where necessary to carry out the terms of such a QDRO, a separate account shall be established with respect to the alternate payee, and such person(s) shall be entitled to make investment selections with respect thereto in the same manner as the participant. All costs and charges incurred in carrying out the investment selection shall be deducted from the account created for the alternate payee making the investment selection.

2. Any amounts so set aside for an alternate payee shall be paid out immediately in a lump sum, unless the QDRO directs a different form of payment or later payment date. Nothing in this §1503.B shall be construed to authorize any amounts to be distributed under the employer's plan at a time or in a form that is not permitted under IRC §457. Any payment made to a person other than the participant pursuant to this §1503.B shall be reduced by required income tax withholding. Such withholding and income tax reporting shall be done under the terms of the *Internal Revenue Code* as amended from time to time.

3. The commission's liability to pay benefits to a participant shall be reduced to the extent that amounts have been paid or set aside for payment to an alternate payee pursuant to this §1503.B. No amount shall be paid or set aside unless the commission, or its agents or assigns, has been provided with satisfactory evidence releasing them from any further claim by the participant with respect to these amounts. The participant shall be deemed to have released the commission from any claim with respect to such amounts in any case in which the commission has been notified of or otherwise joined in a proceeding relating to a QDRO, which sets aside a portion of the participant's account for an alternate payee, and the participant fails to obtain an order of the court in the proceeding relieving the employer from the obligation to comply with the QDRO.

4. The commission shall not be obligated to comply with any judgment, decree or order which attempts to require the Plan to violate any plan provision or any provision of §457 of the *Internal Revenue Code*. Neither the commission nor its agents or assigns shall be obligated to defend against or set aside any judgment, decree, or order described herein or any legal order relating to the division of a participant's benefits under the plan unless the full expense of such legal action is borne by the participant. In the event that the participant's action (or inaction) nonetheless causes the commission, its agents or assigns to incur such expense, the amount of the expense may be charged against the participant's account and thereby reduce the commission's obligation to pay benefits to the participant. In the course of any proceeding relating to divorce, separation, or child support, the commission, its agents and assigns shall be authorized to disclose information relating to the participant's individual account to the participant's spouse, former spouse or child (including the legal representatives of the alternate payee), or to a court.

5. Any Conforming Equitable Distribution Order (CEDO), filed prior to January 2002 may be amended to comply with this §1503.B, pursuant to a Qualified Domestic Relations Orders (QDRO), which is duly filed upon the commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1501 (June 2002).

§1505. Disclaimer

A. The commission makes no endorsement, guarantee or any other representation and shall not be liable to the Plan or to any participant, beneficiary, or any other person with respect to:

1. the financial soundness, investment performance, fitness, or suitability (for meeting a participant's objectives, future obligations under the Plan, or any other purpose) of any investment option in which amounts deferred under the Plan are actually invested; or

2. the tax consequences of the Plan to any participant, beneficiary or any other person.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1502 (June 2002).

Chapter 17. Employer Participation

§1701. Additional Compensation Deferred

A. Notwithstanding any other provisions of this Plan, the employer may add to the amounts payable to any participant under the Plan additional deferred compensation for services to be rendered by the participant to the employer during a payroll period, provided:

1. the participant has elected to have such additional compensation deferred, invested, and distributed pursuant to this Plan, prior to the payroll period in which the compensation is earned; and

2. such additional compensation deferred, when added to all other compensation deferred under the Plan, does not exceed the maximum deferral permitted by LAC 71:VII.303.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1972 (October 1998), amended LR 28:1502 (June 2002).

Chapter 19. Applicable Terms

§1901. Interpretation

A. Governing Law. This Plan shall be construed under the laws of the state of Louisiana.

B. Section 457. This Plan is intended to be an eligible deferred compensation plan within the meaning of §457 of the *Internal Revenue Code*, and shall be interpreted so as to be consistent with such Section and all regulations promulgated thereunder.

C. Employment Rights. Nothing contained in this Plan shall be deemed to constitute an employment agreement between any participant and the employer and nothing contained herein shall be deemed to give a participant any right to be retained in the employ of the employer.

D. Days and Dates. Whenever time is expressed in terms of a number of days, the days shall be consecutive calendar days, including weekends and holidays, provided, however, that if the last day of a period occurs on a Saturday, Sunday or other holiday recognized by the employer, the last day of the period shall be deemed to be the following business day.

E. Word Usage. Words used herein in the singular shall include the plural and the plural the singular where applicable, and one gender shall include the other genders where appropriate.

F. Headings. The headings of articles, sections or other subdivisions hereof are included solely for convenience of reference, and if there is any conflict between such headings and the text of the Plan, the text shall control.

G. Entire Agreement. This Plan document shall constitute the total agreement or contract between the commission and the participant regarding the Plan. No oral statement regarding the Plan may be relied upon by the participant. This Plan and any properly adopted amendment, shall be binding on the parties hereto and their respective heirs, administrators, trustees, successors, and assigns and on all designated beneficiaries of the participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. §42:1301-1308 and IRC §457.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 28:1503 (June 2002).

Title 32
EMPLOYEE BENEFITS

Part IX. Health Maintenance OrganizationsCHMO

Chapter 1. General Provisions

§101. Qualifications

A. Any health maintenance organization (HMO) or other prepaid medical benefits plan seeking to solicit the membership of employees of the state, its agencies or political subdivisions shall be subject to the regulations and requirements as set forth below, unless:

1. the HMO provides evidence of federal qualification under Section 1301 of P.L. 93-222 (Health Maintenance Organization Act of 1973, as amended); and unless

2. the HMO has activated the dual-choice mandate as provided for in Section 1310 of the Act.

B. For purposes of these regulations the term "HMO" is defined as any legal entity which has received a certificate of authority from the Louisiana commissioner of insurance to operate as a health maintenance organization in Louisiana.

C. The Board of Trustees of the State Employees Group Benefits Program specifically reserves the right to disapprove the application of any HMO if, in the opinion of the board, the approval of the application would not serve the best interests of state employees, retirees, and their dependents

D. In the event the HMO seeks to solicit the membership of employees of the state, its agencies or political subdivisions who reside in a service area other than one previously approved by the Board of Trustees, a separate application for the additional service area shall be required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:98 (February 1989).

§103. Requirements

A. The HMO shall furnish the following information:

1. proof that it has received a certificate of authority from the Louisiana commissioner of insurance to operate as an HMO in the state of Louisiana, together with a copy of its application to the commissioner for this certificate;

2. a copy of the form of each booklet or certificate of coverage to be issued to the members, and any changes or amendments as may be made from time to time;

3. an accurate comparison of benefits offered by the HMO and the State Employees Group Benefits Plan;

4. a statement describing the HMO's service area by zip code;

5. a participating HMO shall be required to notify the Board of Trustees of its intent to renew its agreement with the program not less than 120 days prior to July 1. The board may require actuarial justification of the HMO's renewal rate and benefit structure. In any event, the Board of Trustees shall advise the HMO of its intent to accept or reject those rates and benefits no less than 60 days prior to July 1.

B. The Board of Trustees of the State Employees Group Benefits Program shall not be held liable for claims for damages relating to any treatment rendered or arranged for by the HMO.

C. The HMO shall agree to hold the Board of Trustees of the State Employees Group Benefits Program harmless from all claims for damages relating to any act or omission by the HMO, including any claims relating to failure of the HMO to provide services as specified in its contract with the state of Louisiana due to financial hardship or insolvency.

D. The HMO shall agree to hold any plan member or dependent harmless from any liability or cost for health maintenance services rendered during enrollment in the HMO, except as may be specifically provided for in the group contract and individual certificates of coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:98 (February 1989).

§105. Initial Enrollment and Effective Date

A. The initial enrollment period shall be the month of April following the approval of the HMO by the board. The initial effective date shall be the July 1 next following the completion of this enrollment period.

B. The state shall furnish the HMO with a list of agency personnel officers and their addresses to facilitate agency contact,

C. The state shall provide a letter of introduction by the executive director to the personnel officers encouraging their cooperation with the HMO in scheduling meetings and making the offer to eligible employees.

D. The state shall permit the HMO to use its enrollment form to enroll employees who are currently members of the State Employees Group Benefits Program.

E. The HMO shall use the State Employees Group Benefits Enrollment Document if the employee is not a member of the State Plan at the time he elects HMO membership.

EMPLOYEE BENEFITS

F. All documents shall be processed at the State Employees Group Benefits office, including data entry into the billing and eligibility system.

G. During the time an HMO has access to state employees, all marketing material, including written communications, published advertisements, radio and television commercials, etc. shall be submitted to and approved by the State Employees Group Benefits Program prior to issue.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:98 (February 1989).

§107. Computer Interfacing

A. The state shall provide the HMO with a monthly exception tape, detailing by agency: additions, deletions, and changes.

B. The HMO shall maintain all billing records by agency billing codes as established by the State Employees Group Benefits Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:98 (February 1989).

§109. Premium Billing and Transfer

A. The HMO shall bill membership fees in a regular monthly invoice, detailed by agency billing codes as established by the State Employees Group Benefits Program.

B. The state shall transfer the reconciled membership fees to the HMO by the fifteenth of each month for the previous month's billing, Remittance will be itemized by agency.

C. The state shall retain a monthly administrative fee for each individual contract, which fee shall be negotiated prior to the initial effective date of the agreement between the state and the HMO. Adjustment of the administrative fee will be made no more often than once a year and only on the annual re-enrollment date (July 1).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:98 (February 1989).

§111. Rates

A. The HMO shall charge membership fees that are divisible by a number as shall be set forth by the Group Benefits Program.

B. Rates shall be guaranteed for no less than a 12-month period following initial effective date and thereafter shall be

increased no more often than once a year and only on the annual re-enrollment date.

C. Notice of premium adjustments shall be given the state at least 120 days prior to the proposed effective date of such adjustment.

D. The HMO shall use a rate structure with classifications compatible with those used by the State Employees Group Benefits Program. The HMO shall provide justification, if required by the board, for board approval, of the rate differential between classes of contracts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:98 (February 1989).

§113. Eligibility

A. The HMO shall maintain identical eligibility regulations as the State Employees Group Benefits Program with the exception of sponsored adult dependents, who need not be eligible for membership.

B. The HMO shall enroll new employees who choose membership during their initial period of eligibility for an effective date that is compatible with the eligibility requirements of the state program.

C. The HMO shall provide for continuation of membership for surviving spouses and dependents of deceased employees who are HMO members at the time of death. Such continuation provisions shall be identical to those of the Group Benefits Program. Such continuation shall be provided at the benefit level of the group contract and at a cost no greater than comparable monthly premiums charged by the HMO for like classes of group membership. The HMO shall also provide for continuation of coverage under other circumstances as may be required by the program's eligibility provisions or as may be required by state or federal regulations.

D. During initial enrollment and each subsequent annual re-enrollment, the HMO shall offer membership to eligible active employees and eligible retirees on an equal basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:98 (February 1989).

§115. Pre-Existing Conditions

A. The HMO shall impose no limits on coverage for pre-existing conditions for state employees electing membership during their initial period of eligibility.

B. If a state employee fails to elect HMO membership for himself or his dependents during his initial period of eligibility, the HMO, unless prohibited by federal law or regulation, shall impose limitations on coverage for pre-

existing conditions as a requirement for membership, in accordance with the existing regulations of the State Employees Group Benefits Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:99 (February 1989).

§117. Transfers and Terminations

A. The HMO shall hold an annual re-enrollment each April for an effective date of July 1 for employees electing to enter or leave HMO membership. This shall include both active and retired employees.

B. Transfer of coverage from the State Employees Group Benefits Program to the HMO or vice-versa shall be allowed only (during the annual re-enrollment period, for an effective date of July 1 Transfer of coverage shall also be allowed as a consequence of the employee's being transferred into or out of the HMO service area. with an effective date of the first of the month following transfer.

C. The HMO shall provide benefits up to but not beyond (late of discharge in the event a member or his dependents are hospital confined at the time his membership terminates.

D. The HMO shall allow individual conversions for a 30-day period following the end of the month during which an employee terminates his group membership. The conversion may be an individual HMO membership or fully-insured health contract, but shall be offered without regard to existing medical conditions and at the then-current rate for all other similar conversions. Termination of the group contract shall not constitute individual termination for purpose of conversion.

E. No individual membership shall be terminated by the HMO except for just cause.

F. Should the HMO discontinue services for all of its membership in general or for state employees and their dependents in specific, notification shall be given to the Board of Trustees of the HMO not less than 90 days prior to the discontinuance of services. All plan members participating in that HMO will be automatically transferred into the State Employees Group Benefits Program indemnity plan There will be no preexisting condition limitation unless the plan member or dependents had a pre-existing condition limitation in the State Employees Group Benefits Program at the time of transfer to the HMO. The program shall not be responsible for costs for medical services incurred prior to the effective date of transfer. Should a plan member or dependent be confined in a hospital on the effective date of their transfer from the HMO to the state program, the HMO shall remain responsible for that confinement until the discharge.

G. The Board of Trustees specifically reserves the right to cancel any contract between the board and the HMO, with or without cause, with notification to be furnished the HMO not less than 60 days prior to cancellation.

H. Members of a health maintenance organization (HMO) with which the board has contracted, who elect, during the annual open enrollment period to transfer to the State Employees Group Benefits Program indemnity plan on July 1 receive credit for deductible and co-payment amounts met with the HMO during the first six months of the calendar year in which the transfer is made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:99 (February 1989), LR 21:591 (June 1995).

§119. Non-Duplication of Coverage

A. If a husband and wife are both state employees and both are eligible for family coverage under the State Employees Group Benefits Program, both must elect membership in the HMO or the state program. Dual coverage shall not be allowed.

B. If a husband and wife are both state employees and have elected single coverage, each may choose membership in either the HMO or the state program.

C. Regardless of any provision of the State Employees Group Benefits Program contract to the contrary, the following applies to any state employee or dependent enrolled in an HMO.

1. The person shall neither be a member of the state program nor a qualified dependent covered under the state program.

2. No benefits will be payable under the state program with respect to charges for services and supplies furnished while person is enrolled in the HMO.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:99 (February 1989).

§121. Disclosure

A. The HMO shall issue to each employee a description of benefits to which he is entitled under the agreement between the HMO and the state of Louisiana.

B. The evidence of coverage shall contain a clear, concise and complete statement of:

1. the health care services and the insurance or other benefits, if any, to which the member is entitled;

2. any exclusions or limitations on the services as benefits to be provided, including any deductibles and/or co-payment provisions;

3. where and in what manner information is available as how services, including emergency and out-of-area services, may be obtained;

4. the HMO's method for resolving enrollee complaints;

EMPLOYEE BENEFITS

5. conditions of eligibility for employees and their dependents;

6. conditions under which an individual's membership may be terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 14:545 (August 1998), amended LR 15:99 (February 1989).

Title 32
EMPLOYEE BENEFITS
Index

- Actions of Administrator, 61
- Active Employee and Retired Employee Coverage, 17, 41
- Additional Compensation Deferred, 72
- Adjustments for Terminated Employees, 9
- Administrative
 - Fees and Expenses, 61
 - Review, 27, 51
- Admission, 1
- Amendments to the Plan, 70
- Appeals from Medical Necessity Determinations, 27, 51
- Authorization of Loans, 69
- Automated Claims Adjusting, 19, 43
- Ballot
 - Counting, 6
 - Preparation and Distribution, 6
- Balloting Procedure, 6
- Benefit Payments to Other Group Health Plans, 25, 49
- Candidate Eligibility, 5
- Case Management, 20, 44
- Change of Classification, 16, 40
- COBRA, 14, 38
- Collection and Deposit of Contributions, 9
- Commission
 - Authority, 61
 - Duties of, 61
- Composition of Board of Trustees, 5
- Comprehensive Medical Benefits, 32, 56
- Computer Interfacing, 74
- Continued Coverage, 13, 37
- Contributions, 17, 40
- Coordination of Benefits, 22, 47
- Cost Assessment and Allocation for FY 95/96, 10
- Custody of Plan Assets, 64
- Death Benefits, 67
- Default Distribution Option, 67
- Deferral Limitations, 62
- Deferred Commencement Date at Separation from Service, 66
- Definitions, 29, 53, 59
- Delegation, 62
- Dental Surgical Benefits, 21, 45
- Dependent Coverage Only, 17, 41
- Disclaimer, 72
- Disclosure, 75
- Distributions
 - Conditions for, 65
 - Eligible Rollover, 68
 - from the Plan, 65
 - Taxation of, 68
- Election(s), 69
 - Results, 6
- Eligibility, 1, 74
- Employer
 - Modification of Deferral, 63
 - Responsibility, 26, 50
- Enrollment in the Plan, 62
- Exceptions and Exclusions for All Medical Benefits, 21, 45
- Exclusive Provider
 - Organization Criteria, 8
 - Program, 47
- Fee Schedule, 19, 43
- General Provisions, 2
- Guidelines for Partial State Premium Reimbursement, 2
- Initial Enrollment and Effective Date, 73
- In-Service Distributions, 66
- Interpretation, 72
- Investment Options, 64
- Legal Limitations, 25, 49
- Limitations on Distribution Options, 68
- Limited Catch-Up, 62
- Loan Terms and Conditions, 70
- Maximum Loan Amount, 69
- Medical Benefits Apply When Eligible Expenses Are
 - Incurred by a Covered Person, 17, 41
- Medicare Reduction, 21, 45
- Mental Health and Substance Abuse, 34, 58
- Multiple Plans, 64
- Nonassignability, 71
- Non-Duplication of Coverage, 75
- Notice of Intent to Contract, 8
- Organizational Description Purpose of Agency, 1
- Outpatient Procedure Certification (OPC), 20, 44
- Paid and Unpaid Leave of Absence, 69
- Participant
 - Accounts, 65
 - Investment Direction, 64
 - Modification of Deferral, 63
- Payment Options, 67
- Penalty for Late Payment of Premiums, 9
- Persons to be Covered, 11, 35
- Petition(s)
 - Form, 7
 - for Candidacy, 5
- Plan Document and/or Contract Amendments or Termination, 27, 51
- Practices and Procedures, 69
- Pre-Existing Conditions, 74
- Preferred Provider
 - Organization (PPO) Criteria, 8
 - Program, 23
- Premium Billing and Transfer, 74
- Prescription Drug Benefits, 23, 47

EMPLOYEE BENEFITS

Program Responsibility, 26, 50	Severability, 7
Properly Submitted Claim, 25, 49	Severance from Employment, 65
Qualifications, 73	State Contribution toward Retirees' Health Premiums, 9
Qualified Military Service, 64	Statement of Contractual Agreement, 25, 49
Rates, 74	Tax Treatment of Amounts Deferred, 71
Recovery of Overpayments, 26, 50	Termination, 70
Re-Enrollment, 64	Third Party Recovery Provision, 26, 50
Reinstatement to Position Following Civil Service	Transfers
Appeal, 27, 51	and Rollovers, 68
Repayment of Loan, 70	and Terminations, 75
Requirements, 73	Unforseeable Emergency, 66
Retirees with Medicare, 10	Uniform Election Dates, 6
Revocation, 63	Utilization ReviewC Pre-Admission Certification, Continued
Right to Receive and Release Information, 25, 49	Stay Review, 19, 44
Selection of Minority Members, 7	When Claims Must Be Filed, 25, 49